Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. *The **State** of* Kentucky *requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act*.

B. **Program Title**: Home and Community Based Waiver

C. **Waiver Number**: KY.0144

D. **Amendment Number**:

E. **Proposed Effective Date**: (*mm/dd/yy*): 12/1/19

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. *Describe the purpose(s) of the amendment:*

Revisions focus on policies being clarified, updated, and enhanced to offer easier interpretation and improved compliance. Specifically, the policy changes:

- Standardize service definitions to support providers' to deliver services within more waivers to improve service delivery network access for participants
- Create consistent terms, definitions, and alignment of similar process across waivers
- Incorporate precision in how processes are articulated and expectations for responsible parties
- Streamline policies to treat all waiver populations equitably to address stakeholder concerns that some waiver populations get more and some get less, by introducing standards that support individualized service planning
- Confirm waiver language meets the intent of the sub-section, as per *CMS 1915(c) Instructions, Technical Guide and Review Criteria*

3. Nature of the Amendment

A. **Component(s) of the Approved Waiver Affected by the Amendment**. *This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (check each that applies):*

Components of the Approved Waiver	Subsection(s)
Waiver Application	
Appendix A Waiver Administration and Operation	x
Appendix B Participant Access and Eligibility	x
Appendix C Participant Services	x
Appendix D Participant Centered Service Planning and Delivery	x
Appendix E Participant Direction of Services	x
Appendix F Participant Rights	x
Appendix G Participant Safeguards	x
Appendix H Quality Systems Improvement	x
Appendix I Financial Accountability	
Appendix J Cost-Neutrality Demonstration	

B. **Nature of the Amendment**. *Indicate the nature of the changes to the waiver that are proposed in the amendment (check each that applies):*

	Modify target groups(s)
	Modify Medicaid eligibility
	Add/delete services
X	**Revise service specifications**
X	**Revise provider qualifications**
	Increase/decrease number of participants
	Revise cost neutrality demonstration
	Add participant-direction of services
	Other *Specify:*

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. *The **State** of* Kentucky *requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of 1915(c) of the Social Security Act (the Act)*.

B. **Program Title** (*optional – this title will be used to locate this waiver in the finder*): Home and Community Based Waiver

C. **Type of Request**: Amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are daily eligible for Medicaid and Medicare*.)

	3 years	x	**5 years**

Original Base Waiver Number: KY.0144

Draft ID:

D. **Type of Waiver** (*select only one*): Regular Waiver

E. **Proposed Effective Date of Waiver being Amended:** 12/1/2019
Approved Effective Date of Waiver being Amended:

1. Request Information (2 of 3)

F. **Level(s) of Care**: *This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):*

	Hospital *Select applicable level of care*

		Hospital as defined in 42 CFR 440.10 *If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:*
		Impatient psychiatric facility for individuals age 21 and under as provided in 42 CFR 440.160
x	**Nursing Facility** *Select applicable level of care*	
	x	**Nursing Facility as defined in 42 CFR 440.40 and 42 CFR 440.155** *If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:*
		Institution for Mental Disease for persons with mental illness aged 65 and older as provided in 42 CFR 440.140
	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR 440.150) *If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:*	

1. Request Information (3 of 3)

G. **Concurrent Operation with Other Programs**. *This waiver operates concurrently with another program (or programs) approved under the following authorities*

Select one:

x	**Not applicable**		
	Applicable *Check the applicable authority or authorities:*		
		Services furnished under the provisions of 1915(a)(1)(a) of the Act and described in Appendix I	
		Waiver(s) authorized under 1915(b) of the Act. *Specify the 1915(b) waiver program and indicate whether a 1915(b) waiver application has been submitted or previously approved:*	
		Specify the 1915(b) authorities under which this program operates *(check each that applies):*	
			1915(b)(1) (mandated enrollment to managed care)
			1915(b)(2) (central broker)

			1915(b)(3) (employ cost savings to furnish additional services)
			1915(b)(4) (selective contracting/limit number of providers)
		A program operated under 1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*	
		A program authorized under 1915(i) of the Act.	
		A program authorized under 1915(j) of the Act.	
		A program authorized under 1115 of the Act. *Specify the program:*	

H. **Dual Eligibility for Medicaid and Medicare**.

Check if applicable:

x	**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g. the roles of state, local and other entities), and service delivery methods.*

The purpose of this waiver is to prevent institutionalization of waiver participants by offering effective, individualized services that ensure the health, safety and welfare of participants so they may remain in their own home and community.

Goals

Waiver recipients

1) Are safe and healthy while living in the community;

2) Receive effective and individualized assistance; and

3) Have easy access and choice to waiver services.

Objectives

1) Identify individualized needs through an assessment process leading to a comprehensive person-centered service plan,

2) Ensure home and community based services are comprehensive alternatives to institutional services,

3) Improve information, access, and utilization of community based services,

4) Enhance provider competency and continuity of care by enhancing certification and training requirements, and;

5) Clarify rights and responsibilities of employers and employees in participant directed services.

Organizational Structure

The Department for Medicaid Services (DMS) exercises administrative discretion in the operation of the waiver and in setting policies, rules and regulations related to the waiver. DMS or their designee will serve as the operating entity through a contract or memorandum of agreement with DMS.

Service Delivery Methods

The HCBS waiver offers statewide availability of traditional services and the ability to self-direct non-medical services. Participants can choose either all traditional, all participant-directed, or a combination (blend) of traditional and participant-directed services.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed*.

A. **Waiver Administration and Operation**. **Appendix A** *specifies the administrative and operational structure of this waiver.*

B. **Participant Access and Eligibility**. **Appendix B** *specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.*

C. **Participant Services. Appendix C** *specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.*

D. **Participant-Centered Service Planning and Delivery. Appendix D** *specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).*

E. **Participant-Direction of Services**. *When the State provides for participant direction of services,* ***Appendix E*** *specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services.* (*Select one*):

x	**Yes. This waiver provides participant direction opportunities. Appendix E is required.**
	No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. **Participant Rights. Appendix F** *specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.*

G. **Participant Safeguards. Appendix G** *describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.*

H. **Quality Improvement Strategy. Appendix H** *contains the Quality Improvement Strategy for this waiver.*

I. **Financial Accountability. Appendix I** *describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.*

J. **Cost-Neutrality Demonstration. Appendix J** *contains the State's demonstration that the waiver is cost-neutral.*

4. Waiver(s) Requested

A. **Comparability**. *The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.*

B. **Income and Resources for the Medically Needy**. *Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (select one):*

	Not Applicable
	No
X	**Yes**

C. **Statewideness**. *Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (select one):*

x	**No**	
	Yes I*f yes, specify the waiver of statewideness that is requested (check each that applies):*	
		Geographic Limitation. *A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
		Limited Implementation of Participant-Direction. *A waiver of statewideness is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.* *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. **Health & Welfare**: *The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:*

1. *As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;*
2. *Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,*

3. *Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.*

B. **Financial Accountability**. *The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.*

C. **Evaluation of Need**: *The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.*

D. **Choice of Alternatives**: *The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:*

1. *Informed of any feasible alternatives under the waiver; and,*
2. *Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.*

E. **Average Per Capita Expenditures**: *The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in Appendix J.*

F. **Actual Total Expenditures**: *The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.*

G. **Institutionalization Absent Waiver**: *The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.*

H. **Reporting**: *The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.*

I. **Habilitation Services**. *The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.*

J. **Services for Individuals with Chronic Mental Illness**. *The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or*

(3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. **Service Plan**. *In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in Appendix D. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.*

B. **Inpatients**. *In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.*

C. **Room and Board**. *In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in Appendix I.*

D. **Access to Services**. *The State does not limit or restrict participant access to waiver services except as provided in Appendix C.*

E. **Free Choice of Provider**. *In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.*

F. **FFP Limitation**. *In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.*

G. **Fair Hearing**: *The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.*

H. **Quality Improvement**. *The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in Appendix H.*

I. **Public Input**. *Describe how the State secures public input into the development of the waiver*: DMS completed extensive public comment with the revision of the waiver. DMS utilized the following methods to educate the public and engage in meaningful public input.

1) Focus Groups-DMS hosted 40 focus groups across the state to speak with stakeholders to get an understanding of the changes that were most impactful to stakeholders.

2) Dedicated Email box-DMS established a widely publicized email box to receive comments and questions from stakeholders at large. DMS has received well over 300 emails to date.

3) Email Repository-Established continually updated email list of all stakeholders who contacted DMS with comments or provided an email address through in person meetings.

4) Assessment Report-Released an assessment (authored by a contracted entity) of the waivers in a 300+ page report that went into great detail about the climate of the state, nation, and provided 11 recommendations for enhancing the 1915(c) waivers.

5) Formal Response- DMS released a formal response that laid out the framework for the redesign of the waivers.

6) Town Halls-DMS hosted 10 town halls to educate the public about the recommendations and the plan moving forward. The town halls also allowed for public testimony.

7) Public Notice-Released a public notice 30 days prior to release of the waivers. This was posted in all local DCBS offices, posted on the website, shared through social media, and emailed to our email repository

8) Draft Releases of Waivers-Released proposed waivers for public review

9) Webinar Series-DMS released a series of informative webinars to educate the public about the changes that we heard most public comment on and that would be most impactful to external stakeholders.

10) Formal Public Comment-Completed the required 30 day formal public comment period. Providing the option to submit through a) email b) writing c) telephonic.

11) FAQ document-DMS published and updated a FAQ document to provide consistent and timely responses to the most frequently asked questions.

J. **Notice to Tribal Governments**. *The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.*

K. **Limited English Proficient Persons**. *The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance*

to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). Appendix B describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:

Ext:

TTY:

Fax:

E-mail:

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:

Ext:

TTY:

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:

Ext:

TTY:

Fax:

E-mail

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

	Replacing an approved waiver with this waiver.
	Combining waivers.
	Splitting one waiver into two waivers.
	Eliminating a service.
	Adding or decreasing an individual cost limit pertaining to eligibility

	Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
	Reducing the unduplicated count of participants (Factor C).
	Adding new or decreasing a limitation on the number of participants served at any point in time.
	Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.
	Making any changes that could result in reduced services to participants.

Specify the transition plan for the waiver:

The intention of this waiver amendment is to standardize waiver service definitions, operations, and processes to the extent possible, across all of Kentucky's 1915(c) waiver programs. Although service names may change, the intention and availability of services do not change. Updates made to services definitions, limitations and provider qualifications are intended to clarify existing program policies and regulations. Therefore, the Department of Medicaid Services (DMS) does not anticipate participants will experience a reduction is services and a transition plan is not necessary. To assist CMS and the public in understanding the service name updates, DMS has provided the following service names crosswalk:

Service Name Under Currently Approved Waiver	Proposed Service Name
Adult Day Health	Adult Day Health
Conflict Free Case Management	Case Management
Attendant Care	Personal Assistance
Home and Community Supports	Home and Community Supports
Respite	Non-specialized Respite
Specialized Respite	Specialized Respite
Participant Directed Coordination	Participant Directed Case Manager
Financial Management Services	Financial Management Services
Goods and Services	Goods and Services
Home Delivered Meals	Home Delivered Meals
Environmental and Minor Home Modifications	Environmental and Minor Home Modifications

Attachment #2: Home and Community-Based Settings Waiver Transition Plan.

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required. Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Kentucky 1915 (c) HCB Waiver Transition Plan

I. Background

On March 17, 2014, updated Home and Community Based Services (HCBS) final rules became effective in the Federal Register for 1915(c) waivers, 1915(i) state plan services, and 1915(k) community first choice state plan option. As they pertain to 1915(c) waivers, these rules include requirements for several areas of HCBS: all residential and non-residential settings, provider-owned residential settings, person-centered planning process, service plan requirements, and conflict-free case management. The goal of the HCBS final rules is to improve the services rendered to HCBS participants and to maximize the opportunities to receive services in integrated settings and realize the benefits of community living. The Centers for Medicare & Medicaid Services (CMS) is allowing five years (until March 17, 2019) for states and providers to transition into compliance with the all settings and provider-owned settings requirements.

As part of the five year transition period, states must submit transition plans to CMS that document their plan for compliance. The first of these transition plans is a waiver-specific transition plan and is required when a state submits a waiver renewal or amendment. The other required transition plan is a statewide transition plan to bring all 1915(c) waivers into compliance, and is due 120 days after the submission of the first transition plan. The statewide transition plan describes the process to bring all 1915(c) waivers for a state into compliance with the HCBS all settings and provider-owned settings requirements.

Kentucky assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in Kentucky's approved Statewide Transition Plan. Kentucky will implement any required changes upon approval of the Statewide Transition plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

II. Introduction

The Commonwealth of Kentucky (KY) Department for Medicaid Services (DMS) operates the Home and Community-Based (HCB) waiver under the 1915(c) benefit. HCB is a non-residential waiver and includes the option for Participant Directed Services (PDS). HCB participants are individuals who are elderly or disabled and meet nursing facility level of care, but are able to remain in or return to their homes (907 KAR 1:160).

A. Purpose

The purpose of this HCB waiver transition plan is to outline the assessments that DMS has completed, and planned remedial actions to bring this waiver into compliance with the HCB setting final rules. DMS submitted the transition plan specific to the MPW on August 28, 2014 to CMS, which started the 120 day clock to submit the Statewide Transition Plan. The Statewide Transition Plan serves as a guide for transitioning all HCBS waivers into compliance with the all settings and provider-owned settings rules, while this transition plan focuses on the HCB waiver. The goal of the implementation of these requirements is to facilitate the integration and access of waiver participants into the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree as individuals not receiving Medicaid HCBS.

Another objective of this document is to give stakeholders an opportunity to provide input on KY's process to comply with the HCBS final rules. Stakeholders include waiver participants, legal guardians, families, parents, siblings, wives, husbands, advocacy groups, friends, and providers. Throughout this process, one of DMS' goals is to actively engage stakeholders in the implementation of the final rules. For the purposes of this document, if a participant has a legal guardian, the legal guardian is included in all references of the participant.

B. Overview

This Statewide Transition Plan contains the process that DMS is using to evaluate and revise the Kentucky 1915(c) waivers. The first section describes the assessments that were conducted to determine the compliance of each waiver with HCBS final rules at the state level. The assessments focused on two components: policy (regulation and waiver application) and monitoring processes. The second section is the provider assessment, which includes residential and non-residential settings, and the results of provider surveys. After the assessment section, the remedial strategy section is outlined, with a focus on state and provider remedial actions. The state remedial strategy includes four sub-sections: 1) policy, 2) operations, 3) participants, and 4) technology. The provider-level remedial strategy includes the process for settings presumed not to be HCBS as well as suggested sample remedial actions. The fourth and final section of this transition plan includes the process for public comment.

III. Assessment Process – Systemic Review

A. Regulation and Waiver Application Assessment

To evaluate the compliance of the KY HCB waiver with the HCBS final rules, DMS established a regimented process led by a workgroup of staff from three departments representing each waiver from across the Cabinet for Health and Family Services (CHFS). The review included a detailed analysis of the waiver regulation, including manuals incorporated by reference, the application approved by CMS, and related state regulations, such as provider and enrollment regulations, against each requirement of the federal HCBS rule.

The workgroup categorized and color-coded state regulations and applications into three groups: 1) state policy and requirements meet the final rules (green), 2) state policy and requirements have similar language to the final rules, but need to be strengthened (yellow), and 3) state policy and requirements do not specifically address all provisions of final rules, so language needs to be added (red). For group one, no action is required. For group two, language and requirements in state policy have similar language to the final rules, but need to be strengthened. While some operational practices comply with the federal standards,

state policies do not fully meet the final rules, and therefore, DMS needs to implement policy changes. For group three, current state policy does not specifically address all provisions of final rules, so language needs to be added. While some operational practices have similar intent to the federal standards, they do not fully meet the final rules and therefore, DMS needs to add additional requirements to policies.

Below is the summary analysis of the HCB waiver operating in KY as it relates to the HCBS final rules. DMS will need to update waiver policies (regulations), operational areas, and monitoring practices to comply with the final rules. Below are only the applicable HCBS final rules or applicable parts of the HCBS final rules. All HCBS final rules that were edited for the purposes of this document are indicated with an*.

HCB Waiver – Non-residential

Not compliant; minor changes required. State policy and requirements have similar language to the final rules, but need to be strengthened.

- The setting is selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, and preferences.*
- Facilitates individual choice regarding services and supports, and who provides them.

Not compliant with the following rules. Federal language and requirements do not currently exist in state policy and requirements and need to be added.

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Home and community-based settings do not include the following: (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.*

B. Monitoring Process Assessment

DMS has set monitoring requirements for each of the HCBS waiver providers operating in KY and these monitoring processes will continue while providers comply with the HCBS final rules. The workgroup outlined these monitoring processes, including the oversight process and participant and provider surveying process. Each process was then analyzed to determine the impact of the HCBS final rules and areas requiring revision were identified. Some monitoring tools will need to be updated to incorporate the new federal requirements so that state staff evaluates providers appropriately. If necessary, KY will increase the frequency and percentage of providers selected for review to confirm that state staff effectively track provider compliance. After providers have fully implemented the HCBS final rules, monitoring processes will continue with compliant tools and standards. Below describes the current monitoring/oversight process for each waiver, the participant and/or provider surveys that are conducted, and the areas that will need to be updated to comply with the HCBS final rules. If the department acts regarding a certified waiver provider due to the provider's behavior in one 1915(c) HCBS waiver program, the action regarding the certified waiver provider shall apply in every 1915(c) HCBS waiver program in which the provider is participating. PDS is

specifically separated since PDS for all waivers is centrally monitored by state staff through separate waiver monitoring processes.

Current waiver monitoring process:

Current HCB Oversight Process

- Every agency must be licensed as a Home Health agency or Adult Day Health Center
- The DMS contracted Quality Improvement Organization (QIO) agency completes all first line evaluations of HCB providers
- The evaluations are on-site and include quality questions posed to participants (are you treated with respect, are you aware of your case manager, were you given freedom of choice, etc.), agency policies and procedures, billing, and post-payment audits
- Waiver providers are evaluated on a two or three year cycle
- State staff complete second line monitoring for a random sample of the provider evaluations completed by DMS contracted QIO agency
- The citation and sanctions process is outlined in regulation

HCB Participant and Provider Surveys

- Participant interviews are carried out during on-site monitoring

HCB Areas Requiring Revision

- The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules
- State staff and monitoring QIO agency do not base their evaluations on all of the new HCBS rules
- Monitoring process manuals do not include all of the new HCBS rules
- Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

Current PDS Oversight Process

- Every agency is evaluated annually
- The monitoring process includes reviewing participant records, incident reports, and complaints
- Home visits or phone interviews with waiver participants are completed
- The citation and sanctions process is outlined in regulation

PDS Participant and Provider Surveys

- Participant satisfaction surveys are distributed by the provider prior to monitoring and are reviewed by state staff during the monitoring process

PDS Areas Requiring Revision

- The tools, including checklists used during on-site monitoring, do not include all of the new HCBS rules
- State staff do not base their monitoring on all of the new HCBS rules
- Consumer PDS training is not based on the new HCBS rules
- Participant surveys need to be developed focusing on compliance with the HCBS final rules with mechanisms in place to eliminate provider influence

IV. Provider Assessment

To determine the providers' compliance level, the workgroup used a combination of provider surveys and state staff knowledge. Providers "self-assessed" their compliance with the HCBS final rules through surveys, providing examples to demonstrate their compliance. The state staff reviewed the survey results, validated each provider's response, and assigned each provider a level of compliance. In order to validate setting locations, the workgroup mapped the addresses of waiver provider settings and non-HCB settings (ICF/IID, hospitals, institutions for mental disease, and nursing facilities). Locations with high density waiver provider settings and non-HCB settings were analyzed to help determine each provider's compliance level.

Below are the initial categorizations of provider compliance for non-residential providers. This is not intended to be the final analysis of provider compliance with the HCBS final rules, but rather is a starting point to identify areas that providers will need to change to come into compliance. Providers will have ample opportunity to review their compliance level and make modifications where possible to come into compliance. Providers will be notified of their initial compliance level when DMS distributes the compliance plan template, during the first quarter of calendar year 2015.

A. Non-Residential Settings

In addition to a survey targeted for residential providers, the workgroup created a similar survey for non-residential providers that focused on the HCB setting requirements. The workgroup developed this survey using CMS' toolkits and distributed it to non-residential providers via email and provider letters. The non-residential survey is outlined in Appendix A. The target provider types for this survey were adult day health centers (ADHC), home health agencies, adult day training (ADT), and other non-residential waiver providers, such as case managers, who render services to the waiver population. Approximately 40% of the total non-residential waiver providers in the state completed the survey. The providers who responded to the survey render a variety of services, including ADT, ADHC, home health agencies, case management, behavior supports, and physical/occupational/speech therapy.

For non-residential providers who did not complete this survey, DMS will provide additional opportunities for providers to submit information, which will indicate their compliance level. However, DMS believes that the distribution of non-residential providers who completed the survey closely represents the non-residential provider population as a whole.

After receiving providers' responses, the workgroup analyzed the providers' self-reported compliance level. The QA staff reviewed and validated the survey responses and the workgroup then categorized each non-residential provider into one of four compliance levels, as defined by CMS:

- Fully align with the federal requirements
- Do not comply with the federal requirements and will require modifications
- Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
- Are presumptively non-HCB but for which the state may provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

The providers in compliance level four were further analyzed and categorized into the following categories:

- Not isolating – These providers probably fall into compliance level two, but additional information is needed to ensure that these settings will not require heightened scrutiny.
- Potentially isolating – These providers will potentially fall into compliance level four, but additional information is needed to determine if these settings will or will not require heightened scrutiny.
- Isolating – The characteristics of these provider settings are not HCB, but rather institution-like, and these providers will require heightened scrutiny.

The results of the non-residential provider survey and validation by state staff are outlined below. Percentages are used instead of counts because there was not 100% participation among non-residential providers. These percentage estimates are based on the number of provider agencies, not the number of actual settings each provider has. If a provider renders both ADT and ADHC, the provider was only counted once.

Non-Residential Providers (ABI, ABI-LTC, SCL, MPW, HCB) Estimates

Category 1: Fully align with the federal requirements

Estimate Number of Providers: 0 (0%)

Main Areas of Non-Compliance:

Category 2: Do not comply with the federal requirements and will require modifications

Estimate Number of Providers: 62%

Main Areas of Non-Compliance:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices

Category 3: Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals

Estimate Number of Providers: 0 (0%)

Main Areas of Non-Compliance:

Category 4: Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

Estimate Number of Providers - Not Isolating: 5%

Estimate Number of Providers – Potentially Isolating: 18%

Estimate Number of Providers – Isolating: 15%

Main Areas of Non-Compliance:

- Located in a building that is also a facility that provides in-patient institutional treatment
- On the grounds of, or immediately adjacent to an institution
- Setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS
- Operated in an area (e.g., a neighborhood, a street or a neighboring street, etc.) where there is more than one residence in the area that is occupied by individuals receiving HCBS
- Operated in multi-family properties with more than one unit occupied by individuals receiving Medicaid HCBS

- Operated in a remote location (rural, farmstead, etc.)

V. Remedial Strategies

DMS will implement several strategies over the next five years to transition policies and operations into compliance with the HCBS final rules. The strategies identified in this section are the results of assessments completed by the workgroup over the past five months.

A. State Level Remedial Strategies

1. Policy

The workgroup completed a thorough review of waiver regulations and applications, as outlined in section III. The overarching goal is for each regulation and waiver application to be in compliance with the HCBS final rules. The following includes the identified changes to each regulation and application that are required to transition the HCB waiver policies into compliance with each HCBS rule related to settings.

DMS is implementing the HCBS final rules in two rounds to assure that providers have adequate time to become compliant with all rules. Additional reasons for the extended timeline are as follows.

1. The rules included in the second round may have a significant impact on KY HCBS providers and create an access issue depending on the number of providers who will lose the ability to render services because of the rules, if adequate time is not allowed for implementation.

2. DMS has allotted a full year to work with the high volume of providers who will need to undergo heightened scrutiny to assure that DMS can spend adequate time working with each provider.

3. DMS is giving time for providers to stabilize the first round of changes before moving into the second round.

4. DMS will be educating providers as soon as the rules are fully defined and operationalized. The education and compliance process for the second round changes will start before 2018 giving providers ample time to become compliant.

Potential HCB Waiver Regulation and Application Actions for Compliance

Rule: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS

Timeline: 7/15/2017 – 1/1/2018 (Second Round)

Status: Not Started

Potential Actions to be Compliant:

- Clarify indicators of integration into the greater community and incorporate into the regulation
- Add stronger language that focuses on outcomes related to the individual's experience
- Identify potential opportunities to use technology to promote integration

- Include clarifying language that community integration is individualized, appropriate, and outlined in the plan of care (POC)

Rule: The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Include assurance that individuals must be informed of every available setting option each time s/he is selecting a new setting, every time the individual moves or changes service provider
- Require case manager to document all available settings options considered and selected by the individual in the POC
- Include explanation of how informed choice should be provided
- Include assurance that the individual is included in both the selection of the provider and setting (location), and describe how the setting options were presented to the participant

Rule: Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Add language ensuring the individual's privacy, dignity, and respect

Rule: Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant:

- Add general language to clearly define this rule
- Add language allowing the individual to select daily activities and with whom they interact

Rule: Facilitates individual choice regarding services and supports, and who provides them.

Timeline: 1/1/2015 – 4/30/2015 (First Round)

Status: Not Started

Potential Actions to be Compliant (HCB Application):

- Add clear and centrally located definition of freedom of choice

Potential Actions to be Compliant (HCB Regulation):

- Use HCBS rule language

Rule: Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

Timeline: 7/15/2017 – 1/1/2018 (Second Round)

Status: Not Started

Potential Actions to be Compliant:

- Include restrictions for providers that have qualities of an institutional setting
- Include restrictions for providers that are located within, on the grounds of, or immediately adjacent to a public institution, or any other setting that has the effect of isolating individuals receiving HCBS
- Include HCBS rule language

DMS will submit revised ordinary regulations for setting-related rules in two rounds in order to allow stakeholders time to review and providers time to implement. The HCBS final rules will be implemented in two rounds based on the ease of implementation and complexity of the change. DMS will draft the regulation language for the first round from January 1, 2015 to February 28, 2015. The first round of revised ordinary regulations will be submitted in April 2015 and effective in November 2015. DMS will draft the regulation language for the second round from July 2017 to October 2017. The second round of revised ordinary regulations will be submitted in January 2018, with an effective date in July 2018, and an implementation date of January 2019. The implementation date of January 2019 is when all providers must be compliant with all HCBS settings final rules.

DMS will draft the waiver amendment language for the first round from January 1, 2015 to February 28, 2015. The revised waiver amendments are targeted for submission to CMS for approval on the below date. This date was selected to coincide with the waiver renewal date and is during the regulation adoption timelines to assure consistency.

- HCB – April 1, 2014

To confirm that the applications and regulations mirror the same requirements for the HCB waiver, DMS will draft the waiver amendment language for the second round from November 2017 to March 2018 and submit the revised waiver application to CMS for approval in April 2018. The goal is for the both the regulations and applications to be approved and effective in July 2018.

2. Operations

State staff and the workgroup will be preparing operational practices for compliance over the next three years. This includes developing a tool for providers that outlines the federal requirements and how they will be evaluated, and hosting a webinar for waiver providers. Once updated state policies take effect, state staff will transition from current operational practices to revised, compliant protocols to administer the HCBS waivers. The HCBS final rules affect several areas of DMS' waiver operations including, but not limited to, internal processes, monitoring, and service delivery. Below is a list of operational changes required for each waiver to bring their practices into compliance.

Potential Waiver Operational Actions for Compliance

Internal Processes

Prior Authorizations

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update PA processes to incorporate new HCBS rules in regards to the participant setting selection process

State staff training

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Train PA staff, focusing on the POC and case management in relation to PAs
- Train state staff, including waiver and QA staff, on HCBS rules
- Train state staff, including waiver and QA staff, on the transition process, new monitoring processes and checklists, related to the HCBS rules

Capacity, resources and services

Timeline: 10/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Evaluate provider capacity throughout the state
- Determine appropriateness of resources for providers
- Evaluate if covered services are adequately meeting the needs of the participants, in view of any changes required by the HCBS final rules

Provider Processes:

Requirements (mission/values)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Providers should update their mission/values and policies/procedures to align with the new DMS regulations

Trainings

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Action to be Compliant:

- Update relevant provider trainings and offer providers all relevant information and trainings

Transition Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop HCBS evaluation tool (monitoring tool) and HCBS compliance plan template to be used by providers, outlining their plan for complete compliance
- Host webinars for waiver providers
- Validate each provider's compliance level during annual evaluation
- Notify providers outlining their compliance level
- Complete on-site reviews for all groups based on provider and waiver staff provider evaluations
- Review, track, and approve/deny the providers' HCBS compliance plans
- Assist providers to ensure compliance and resolve any access issues found
- Use processes outlined in state regulations for provider corrective action or actions not to certify or to terminate non-compliant providers

Monitoring Processes:

Requirements

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Validate that the current monitoring processes are sufficient to monitor new and existing providers against the HCBS rules and modify as necessary

Tools (on-site items, checklists, etc.)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update provider checklists and survey tools for provider sites (residential, ADT, ADHC, etc.) based on the revised regulations that comply with the HCBS rules
- Implement provider requirements using the CMS toolkit to determine the materials/evidence providers need to submit as validation of HCB setting under heightened scrutiny

Surveying Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Update PDS provider on-site surveys
- Establish process for participant surveys

Grievance Process

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Review grievance process and implement updates as needed for participants to file complaints about non-compliant providers
- Determine method to confirm participants are aware of grievance process

Miscellaneous:

Communication plan for additional stakeholders (advocacy groups, provider associations, etc.)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop stakeholder engagement process to obtain input on implementation of the final rules, focusing on defining and operationalizing rules before policies and tools are established
  - Host public forums and/or focus groups for providers and participants, representatives, family members, and advocates
  - Attend meetings of established public consumer, advocacy, and provider groups to review and provide feedback on key changes
  - Accept public comments from stakeholders during public comment periods for waiver regulations, waiver amendments, and waiver renewals
- Communication activities could include periodic email updates with rule summaries, educational materials, webinars, and presentations at conferences and advocacy group meetings upon request

Relocation Process (due to HCBS rules)

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Determine relocation process

3. Participants

The significance of the changes to DMS' HCBS waivers warrants continuous communication with waiver participants and advocacy groups that communicate with participants and their families. Communicating regularly with participants also provides opportunities for state staff to conduct further monitoring of providers. In addition to public notices, state staff will organize outreach to participants to inform them of the key changes to their programs, and confirm they understand their rights. In certain cases, participants may need to be relocated based upon the results of the provider assessments. If the provider falls under

compliance level three (not compliant and never will be), state staff will follow the same protocols to relocate participants as currently are in place when providers are terminated.

Potential Participant Actions for Compliance

Rule: ALL HCBS rules

Timeline: 1/1/2015 – Ongoing

Status: Not Started

Potential Actions to be Compliant:

- Develop stakeholder engagement and education plan and implement process for informing participants of the HCBS rules
- Send information to waiver participants targeted to each participant's situation explaining waiver changes related to HCBS rules
  - Include information outlining the new participant rights, provider requirements, and links to all related information

4. Technology

Kentucky has operated the Kentucky Health Benefit Exchange (KHBE), also known as kynect, since October 2013. Included in the next release of KHBE in April 2015, is a Medicaid Waiver Management Application (MWMA), which converts the majority of waiver processes to a central online system. The system tracks the application, assessment, and POC process. Many of DMS' existing waiver forms will be switched from paper to electronic through MWMA, and the HCBS setting final rules impact the language that must be included in the MWMA screens. Below are the primary changes required for the MWMA to comply with the federal requirements.

Medicaid Waiver Management Application

Timeline: 1/1/2015 – 12/15/2015

Status: Not Started

Potential Technology Actions for Compliance

Forms: Plan of care/prior authorization form, long term care facilities and home and community based program certification form,

Medicaid waiver assessment form, demographic and billing information form, and freedom of choice and case management conflict exemption form

- Modify forms/screen within MWMA to comply with HCBS rules

B. Provider Level Remedial Strategies

As described in section III, the workgroup categorized providers into four compliance levels on a preliminary basis: 1) fully aligned with federal requirements and require no changes, 2) do not comply with federal requirements and require modifications, 3) cannot meet the federal requirements and require removal from the program and relocation of individuals, and 4) presumed not to be HCB and requires heightened scrutiny. The preliminary compliance level of each provider was determined based on surveys and state staff knowledge, but it may change over time, as additional information is obtained and providers present evidence of their compliance.

The compliance plan template is a tool that the HCBS workgroup will be developing with input from stakeholders to assist providers in identifying potential areas of non-compliance. This tool is meant for collaboration and is not a corrective action plan. State staff will implement the following activities from January 2015 to July 2018 to assist providers in transitioning to compliance.

1. Develop an HCBS evaluation tool (monitoring tool) and HCBS compliance plan template for providers to be notified of their initial compliance and identify actions they will complete to address areas of non-compliance

a. Distribute HCBS compliance plan template to providers and inform them of their compliance level

b. First round: January 2015 to March 2015

c. Second round: July 2017 to September 2017

2. Develop and implement HCBS final rule communication plan for providers and stakeholders through webinars, presentations at conferences, and provider association meetings

a. The HCBS compliance plan template will follow similar protocols to the current waiver provider corrective action plan (907 KAR 7:005 – section 4)

b. First round: April 1, 2015 to April 30, 2015

c. Second round: October 2017 to January 2018

3. State staff will review and approve/deny providers' plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

4. Conduct routine evaluations and on-site assessments with the updated HCBS evaluation tool to validate each provider's compliance plan and level of compliance

a. Both rounds: March 2015 to ongoing

For providers in compliance level one (fully align with federal requirements), there will be no changes required of the provider and they can continue providing services. State staff will continue to monitor these providers and participants with on-site visits to verify compliance based on the HCB waiver's updated monitoring process (as outlined in section III).

For providers in compliance level two (do not comply and require modifications), changes are required for the provider to become compliant with the HCBS setting rules. These changes may be short-term (0-3 months) or long-term (3-12 months), but all changes must be completed before the updated state policies are implemented in January 2019. The remedial activities included below are examples of activities that the providers may complete to come into compliance with the HCB setting rules. State staff will implement the following activities from January 2015 to July 2018:

1. Track provider compliance plans

a. First round: May 2015 to October 2015

b. Second round: January 2018 to June 2018

2. Conduct routine on-site monitoring to review providers' progress towards complete compliance

a. Both rounds: March 2015 to ongoing

3. For non-compliant providers, the HCB waiver will follow the termination process outlined in Kentucky regulations

For providers in compliance level three (not compliant and never will be), state staff will complete an additional on-site meeting with the provider to confirm that the setting does in fact fall under compliance level three. If after the on-site meeting, the setting is confirmed to be in compliance level three, state staff will offer the opportunity for the provider to relocate the setting before the updated state policies become effective. If the provider is able to successfully relocate to a setting that complies with the federal requirements and to assure that operations in that setting comply with the HCBS rules, the provider will not be terminated. Should a provider not comply or qualify with HCBS rules for a particular service, they could potentially provide other HCBS services, as long as they comply with the applicable HCBS requirements for those services. However, if the provider chooses not to relocate, is unable to find an appropriate setting, or is unable to come into compliance with the HCBS rules, the provider will be terminated. The provider's termination will be based on 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) after revised waiver regulations are effective. DMS will identify the waiver participants who will be impacted by provider termination and the process will be outlined. All affected participants will be relocated within 90 days of their providers' termination, following the current relocation process. The relocation process will follow the person-centered planning process. The state staff will provide reasonable notice and due process to all parties. If state staff determines the provider should not be in compliance level three, then they will fall under compliance level four and will require heightened scrutiny.

1. Settings presumed not to be HCB

For settings in compliance level four (presumed not to be HCB), providers will be required to submit evidence to the state first, outlining how their settings do not have the qualities of an institution and do have the qualities of an HCB setting. State staff will conduct an additional on-site assessment and will coordinate closely with these providers to verify they are providing the necessary documentation to prove they have the qualities of HCB setting. DMS will corroborate provider evidence and determine whether to send the evidence to CMS for the heightened scrutiny process. DMS will further define the process of heightened scrutiny when further guidance is provided by CMS. To assist providers in establishing evidence that they have the qualities of an HCB setting, state staff will complete the following activities from January 2016 to July 2018.

1. Notify providers that they will need to undergo heightened scrutiny
2. Collaborate with providers on additional documentation that must be presented as evidence of being HCB
3. Add additional requirements to the HCBS compliance plan template
4. Conduct additional detailed on-site visits to obtain further evidence, as needed
5. Submit provider's evidence to CMS for determination
6. For non-compliant providers or providers determined not to be an HCB setting, the termination process outlined in regulation 907 KAR 7:005 (Certified waiver provider requirements) or 907 KAR 1:671 (Conditions of Medicaid provider participation; withholding overpayments, administrative appeal process, and sanctions) will be followed

Once these providers submit evidence of having the qualities of HCB settings in the HCBS compliance plan template, state staff will evaluate the provider's submission. As needed, state staff will reserve time for more assessments and will prioritize this group of providers when scheduling on-site evaluations. After state staff's analysis, the provider's evidence will be submitted to CMS for final determination. If the determination is that the provider does not have the qualities of a HCB setting, state staff will evaluate the provider as now falling under compliance level three, and the provider will need to relocate the setting and comply with all HCBS rules, or face termination.

Below includes some examples of suggested provider level remedial activities that providers may complete to come into compliance with the HCB setting rules. The activities are identified as short-term (0-3 months) or long-term (3-12 months) depending on their ease of implementation.

Potential Provider Actions for Compliance

Provider Requirements

Rule: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;

Potential Actions to be Compliant:

- Short-term (based on the individual's person-centered plan)
  - Assist/provide training to individuals on how to access public transportation
  - Support individuals in their job search with activities such as supported employment
  - Encourage individuals to participate in community activities of their choosing and explore community access opportunities
  - Ensure individuals have access to personal resources
  - Provide staff training
- Long-term
  - Provide transportation to community activities if public transportation is not available
  - Work with individuals to help them establish valuable relationships within the community
  - Update mission/values to meet the rule

Rule: The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board

Potential Actions to be Compliant

- Short-term (based on the individual's person-centered plan)
  - Provide individuals with all setting options available and ensure individual makes an informed choice for both setting and provider
  - Case manager must offer each individual a private unit if available in the setting selected
  - Document all setting and provider options presented and considered by the individuals in the POC
  - Ensure setting options align with individual's needs and preferences
  - Provide staff training

Rule: Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint

Potential Actions to be Compliant

- Short-term (based on the individual's person-centered plan)

- o Ensure individual has privacy
- o Encourage the individual to come and go as s/he wishes, consistent with the POC and provide necessary supports to facilitate
- o Ensure provider staff speak to individuals with respect
- o Provide staff training
- • Long-term
- o Update and implement mission/values to meet the rule

Rule: Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact

Potential Actions to be Compliant

- • Short-term (based on the individual's person-centered plan)
- o Encourage the individual to create his/her own schedule and provide necessary supports to facilitate
- o Encourage the individual to make independent choices during POC planning and on a daily basis
- o Establish policies and procedures which encourage individual choice of activities
- o Provide staff training
- • Long-term
- o Update and implement mission/values to meet the rule

Rule: Facilitates individual choice regarding services and supports, and who provides them

Potential Actions to be Compliant

- • Short term (based on the individual's person-centered plan)
- o Provide necessary information (documents, site visits, etc.) that allows the individual to indicate his/her preferences for services and supports and who provides them
- o Document all setting and provider options presented and considered by the individuals in the POC
- o Provide staff training

Rule: Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings

Potential Actions to be Compliant:

- Short-term (based on the individual's person-centered plan)
  - Depending on compliance level, develop compliance plan to become compliant with HCBS rules
  - Consolidate evidence of community integration among recipients
  - Provide evidence that setting does not have qualities of an institution
  - Remove isolating barriers or institutional qualities
  - Provide staff training
- Long-term
  - Cooperate with state staff and CMS on-site assessments

VI. Public Comment Process

This Statewide Transition Plan was submitted to CMS and posted on December 19th, 2014. The following website can be used to view the plan: http://www.chfs.ky.gov/dms.

In order to allow stakeholders time to provide input in a convenient and accessible manner, DMS submitted this Statewide Transition Plan for public comment through an announcement on the DMS website, publication in newspapers, public forum, and informal channels. The public notice was published and posted on November 5, 2014 and provided stakeholders a 30-day public notice and comment period. CHFS distributed individual emails to waiver providers, provider associations, members of the HB144 Commission and the Commonwealth Council on Developmental Disabilities (CCDD), and DMS' advocacy distribution list to notify those stakeholders of the Statewide Transition Plan. The following website can be used to view the proposed Statewide Transition Plan: http://www.chfs.ky.gov/dms.

The public notice and comment period was published in six newspapers (Lexington Herald Leader, Cincinnati/Northern KY Enquirer, Louisville Courier Journal, Bowling Green Daily News, Owensboro Messenger, Kentucky/Cincinnati Enquirer) on November 5, 2014. DMS and the workgroup also promoted and made informal communication about the transition plan and comment period to the following groups: waiver providers, provider associations, HB144 Commission members, the Commonwealth Council on Developmental Disabilities, and other advocacy groups.

A. Public Comments

All public comments were submitted to DMS through mail, email, advocacy groups and the HB144 Commission meeting and were evaluated by the workgroup. The workgroup categorized similar comments together, summarized the comments, and responded and/or updated the transition plan accordingly. The summary and response of all comments is described below. If the state's determination differed from the public comment, then additional evidence and the rationale the state used to confirm its determination was included. If the state's determination agreed with the public comment, then the location of the supporting evidence in the transition plan was indicated. All public comments on the transition plan will be retained and available for CMS review during the duration of the transition period or approved waiver, whichever is longer.

Summary of modifications based on public comments:

- I. Background – more details added
- II. Introduction – references added

- II. Introduction
  - A. Purpose – more details and public forums added
- III. Assessment Process Systemic Review
  - A. Regulation and Waiver Application Assessment – more details and participant surveys added
- IV. Provider Assessment – more details added
- IV. Provider Assessment
  - B. Non Residential Settings – more details added
- V. Remedial Strategies
  - A. State Level Remedial Strategies
    - 1. Policy – more details added
- State staff training – more details added
- Capacity, resources, and services – section added
- Surveying process – participant surveys added
- Grievance process – section added
- Communication plan for stakeholders – stakeholder engagement process added
  - B. Provider Level Remedial Strategies – more details added
    - 1. Settings presumed not to be HCB – clarifications added
    - Clarifications added

At the time the Statewide Transition Plan is filed with CMS, the transition plan will also be posted to the state website. The URL for the filed transition plan is http://www.chfs.ky.gov/dms. The Statewide Transition Plan, with any modifications made as a result of public input, will be posted for public information no later than the date of submission to CMS.

VII. Appendix

A. Non-Residential Provider Survey

The below survey questions were administered to all non-residential waiver providers through a web-based survey tool. The providers were notified of the survey either by email or provider letter.

1. Name:

2. Agency:

3. Email Address:

4. Please provide the addresses of all of your settings, if applicable:

5. Please select the Medicaid HCB waiver for which your agency/organization provides services: ABI, ABI-LTC, HCB, MPW, MII or SCL

6. Please select which of the following provider types best describes your agency: ADHC, Home Health Agency, or Other

i. Other Non-residential Provider (specify here): ADT, Case Management, OT, PT, ST, CLS, etc.

7. Are participants' schedules for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?

i. Please explain how privacy is ensured/protected:

8. As part of your waiver services, do your participants participate in activities in the greater community?

i. Please provide examples of activities that participants engage in in the greater community:

9. Do participants have the freedom to make their own choices while receiving services at your program (if s/he is able to make independent choices)?

i. Consider the following in your response:

1. Do participants have autonomy to choose daily activities?

2. Do participants choose who they interact with?

ii. Please provide examples of how participants have freedom of choice:

10. Do you facilitate the participants' choice of services, supports, and who provides them?

i. Please explain:

11. Are participants given a choice of available options regarding where to receive services (not applicable to ADHCs)?

i. Please explain how the participants are given choice:

12. Is it made clear that participants are not required to adhere to a set schedule for activities, etc.?

i. Please explain your response to set schedules for participants:

13. Do participant schedules vary from others in the same setting?

i. Please explain your response to varying schedules among participants:

14. Do participants have access to things that interest them and can they schedule such activities at their convenience?

15. Are any of your programs within, on the grounds of, or adjacent to, an institution (nursing facility, institution for mental disease, intermediate care facility for participants with intellectual disabilities, or hospital)?

i. Please provide address/addresses of any programs within, on the grounds of, or adjacent to, an institution:

16. Do any of your programs operate in an area (e.g. a neighborhood, a street or a neighboring street, etc.) where there is more than one facility/program in the area providing services to individuals receiving Medicaid Home and Community-Based Services (HCBS)?

i. If you answered yes in the previous question, please provide examples of how your agency helps participants engage in the broader community:

ii. Please provide the address/addresses of your programs where there is more than one facility/program in the area providing services to individuals receiving Medicaid HCBS:

17. Is the non-residential site considered to be remote and outside of a city limits?

18. Do you ensure that participants have rights of privacy, dignity and respect, and freedom from coercion and restraint?

i. Please provide justification that you ensure participants have rights of privacy, dignity and respect and freedom from coercion and restraint:

19. Does staff converse with participants while providing assistance and during the regular course of daily activities?

20. Does staff address participants in the manner in which they would like to be addressed?

21. Is individual choice facilitated in a manner that leaves the participant feeling empowered to make decisions?

i. Please provide justification that individual choice is facilitated to make the participant feel empowered:

22. Does staff ask participants about their needs and preferences?

23. Does your program accommodate the participant's needs and preferences?

i. Please explain how your program does, or does not, accommodate the participant's needs and preferences:

24. Do participants know how to change or request a change to their program, service, or activity they receive?

25. Does the participant know how and to whom to make a request for a new provider?

i. Please explain the process for how participants request a new provider:

26. Do you ask your participants if they are satisfied with their services, outside of surveying?

i. If yes, please explain how you use that information:

ii. If no, please explain why you do not ask the participants if they are satisfied:

Additional Needed Information (Optional)

Provide additional needs information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation**. *Specify the state line of authority for the operation of the waiver (select one):*

X	**The waiver is operated by the State Medicaid agency.** *Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (select one):*	
		The Medical Assistance Unit *Specify the unit name*:
	X	**Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.** *Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency*: Division of Community Alternatives

	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. *Specify the division/unit name*:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

2. Oversight of Performance.

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency**. *When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:*

DMS has a written Memorandum of Agreement (MOA) with their sister agencies, Department of Behavioral Health Developmental and Intellectual Disabilities (DBHDID) and Department of Aging and Independent Living (DAIL) that is reviewed annually and is updated as needed. DMS may delegate some of the operating functions through the MOA. Functions that may be delegated may include but not limited to:

1. Quality assurance and quality improvement activities. Quality assurance and improvement activities including but not limited to, provider certification and recertification reviews, monitoring of critical incidents and mortality reviews.
2. Review of PDS legally responsible requests
3. Technical assistance and training

DMS uses the following method to monitor delegated functions are in accordance with the written MOA and waiver requirements by:

1. Collecting and reviewing required monitoring reports in accordance with the MOA.
2. Conducting monthly meetings between the Medicaid and operating agencies.

b. **Medicaid Agency Oversight of Operating Agency Performance**. *When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:*

As indicated in section 1 of this appendix, the waiver is not operated by an operating agency, thus this section does not need to be completed

3. **Use of Contracted Entities**. *Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (select one):*

X	**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).** *Specify the types of contracted entities and briefly describe the functions that they perform. Complete Items A-5 and A-6.:* DMS contracts with a state university for the independent assessment function. DMS also has MOAs, as noted above, with the sister agencies and an additional MOA, through DMS, with Department of Community Based Services (DCBS) for review of financial eligibility and to conduct all level of care evaluations for the waiver population.
	No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. **Role of Local/Regional Non-State Entities**. *Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (Select one):*

X	**Not applicable**	
	Applicable - *Local/regional non-state agencies perform waiver operational and administrative functions.* *Check each that applies*:	
		Local/Regional non-state public agencies *perform waiver operational and administrative functions at the local or regional level. There is an* ***interagency agreement or memorandum of understanding*** *between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.* *Specify the nature of these agencies and complete items A-5 and A-6:*
		Local/Regional non-governmental non-state entities *conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency*

		*(when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).* *Specify the nature of these entities and complete items A-5 and A-6:*

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities**. *Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:*

   The Department for Medicaid Services (DMS) is responsible for assessing the performance of the contracted entities providing the functions described in section 3 of this appendix.

6. **Assessment Methods and Frequency**. *Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:*

   DMS assesses the performance of the contracted entities continually through policy clarification and reporting as stipulated in the entities contract.

7. **Distribution of Waiver Operational and Administrative Functions**. *In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (check each that applies):*

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.

Function	***Medicaid Agency***	***Contracted Entity***
Participant waiver enrollment	*X*	
Waiver enrollment managed against approved limits	*X*	
Waiver expenditures managed against approved levels	*X*	
Level of care evaluation	*X*	

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Review of Participant service plans	*X*	
Prior authorization of waiver services	*X*	
Utilization management	*X*	
Qualified provider enrollment	*X*	
Execution of Medicaid provider agreements	*X*	
Establishment of a statewide rate methodology	*X*	
Rules, policies, procedures and information development governing the waiver program	*X*	
Quality assurance and quality improvement activities	*X*	

Appendix A: Waiver Administration and Operations

Quality Improvement: Administrative Authority of the Since Medicaid Agency

a. **Methods for Discovery:**

Methods for Discovery:	*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*					
Sub-assurance:	*N/A*					
Performance measure:	Percentage of required reports contracted entities provides to DMS within the required timeframes. N=The number of required reports contracted entities provided to DMS within the required timeframes. D=The number of required reports due to DMS within the required timeframes					
Data Source: Reports submitted to DMS						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*

	X	*Other* *Specify:* Delegated Entities	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*
Sub-assurance:	*N/A*
Performance measure:	Percentage of required reports the operating agencies provides to DMS within the required timeframes. N=the number of reports the operating agencies provided to DMS within the required timeframes. D=The number of required reports the operating agency was required to provide to DMS within the required timeframes.

Data Source: Reports submitted to DMS						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	State Medicaid Agency		Weekly	X	100% Review
	X	Operating Agency		Monthly		Less than 100% Review Confidence interval: 95%
		Sub-State Entity	X	Quarterly		Representative Sample

						Confidence interval=
		Other Specify: Delegated Entity	X	Annually		Stratified. Describe Group:
				Continuously and Ongoing		Other Specify:
				Other Specify:		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
		State Medicaid Agency		Weekly
	X	Operating Agency		Monthly
		Sub-State Entity	X	Quarterly
		Other Specify:	X	Annually
				Continuously and Ongoing
				Other Specify:

Methods for Discovery:	*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*
Sub-assurance:	*N/A*
Performance measure:	Provider certification and re-certification by the contracted entity shall be conducted according to an on-going provider schedule. N = Number and percent of provider certifications and recertifications completed in accordance to on-going provider schedule. D = Number and percent of provider certifications and recertifications required to be completed in accordance with schedule.

Data Source: Provider certification documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review*

						Confidence interval:
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify:* Delegated Entity	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Identified problems are researched and addressed by DMS through the use of generated quarterly reports. DMS monitors to ensure that contract objectives and goals are met as appropriate.

b. Method for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Identified problems are researched and addressed by DMS through the use of generated quarterly reports. DMS monitors to ensure that contract objectives and goals are met as appropriate. Should the contracted entity not meet the requirements then a corrective action plan is required and/or a recoupment of funds may occur.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
X	*State Medicaid Agency*		*Weekly*
	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
	Other *Specify:*	X	*Annually*
			Continuously and Ongoing
			Other *Specify:*

c. Timeline

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

x	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation*.

Appendix B: Participant Access & Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). *Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group		***Included***	***Target SubGroup***	***Minimum Age***	***Maximum Age***	
					Maximum Age Limit	***No Maximum Age Limit***
X	*Aged or disabled, or both – General*					
		X	*Aged*	65		X
		X	*Disabled (physical)*	0		X
		X	*Disabled (other)*	0		X

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or disabled, or both – Specific recognized subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Intellectual Disability or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Intellectual Disability			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

b. Additional Criteria. *The State further specifies its target group(s) as follows*:

Individuals who meet the Nursing Facility Level of Care regulation as defined in the 907 KAR 1:022.

c. **Transition of Individuals Affected by Maximum Age Limitation.** *When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (select one):*

X	***Not applicable. There is no maximum age limit***
	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Appendix B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** *The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (select one). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:*

X	**No Cost Limit.** *The State does not apply an individual cost limit. Do not complete Item B-2-b or item B-2-c.*
	Cost Limit in Excess of Institutional Costs. *The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. Complete Items B-2-b and B-2-c.*
	The limit specified by the State is (select one)
	A level higher than 100% of the institutional average. *Specify the percentage*:
	Other *Specify*:
	Institutional Cost Limit. *Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. Complete Items B-2-b and B-2-c.*
	Cost Limit Lower Than Institutional Costs. *The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver*. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*
	The cost limit specified by the State is *(select one):*
	The following dollar amount: *Specify dollar amount*:
	The dollar amount (*select one*)
	Is adjusted each year that the waiver is in effect by applying the following formula: *Specify the formula*:

		May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
		The following percentage that is less than 100% of the institutional average: *Specify percent*:
		Other: *Specify*:

Appendix B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2 -a indicate that you do not need to complete this section.

Appendix B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. *The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:*

Table: B-3-a

Waiver Year	*Unduplicated Number of Participants*
Year 1	17050
Year 2	17050
Year 3	17050
Year 4	17050
Year 5	17050

b. **Limitation on the Number of Participants Served at Any Point in Time.** *Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (select one):*

X	***The State does not limit the number of participants that it serves at any point in time during a waiver year.***
	The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	***Maximum Number of Participants Served At Any Point During the Year***
Year 1	N/A
Year 2	N/A
Year 3	N/A
Year 4	N/A
Year 5	N/A

Appendix B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** *The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (select one):*

X	***Not applicable. The state does not reserve capacity.***		
	The State reserves capacity for the following purpose(s).		
	Purpose(s) the State reserves capacity for:		
	Purpose (provide a little or short description to use for lookup): *Purpose (describe):*		
	Describe how the amount of reserved capacity was determined:		
	The Capacity that the state reserves in each wavier year is specified in the following table:	*Year 1*	
		Year 2	
		Year 3	
		Year 4	
		Year 5	

Appendix B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** *Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):*

X	***The waiver is not subject to a phase-in or a phase-out schedule.***
	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. **Allocation of Waiver Capacity.** *Select one:*

X	***Waiver capacity is allocated/managed on a statewide basis.***
	Waiver capacity is allocated to local/regional non-state entities.
	Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. *Specify the policies that apply to the selection of individuals for entrance to the waiver:*

When a waiver has open slots, eligible applicants are selected for entrance based on the date of their application. If the waiver has a wait list, entrants will be selected based emergent risk as evidenced by the following circumstances:

- Abuse, neglect, and/or exploitation of the participant or perpetrated by the participant and substantiated by DCBS
- Death of a primary caregiver with the lack of an alternative caregiver
- Jeopardy to the participant's health and safety due to the primary caregiver's physical or mental health status
- Imminent institutionalization in a long-term care facility
- Discharge from institutional setting with additional needs

Appendix B-3: Number of Individuals Served (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B-4: Eligibility Groups Served in the Waiver

a.

***1.* State Classification.** *The State is a (select one):*

X	**§1634 State**
	SSI Criteria State
	209(b) State

***2.* Miller Trust State.** *Indicate whether the State is a Miller Trust State (select one):*

	No
X	**Yes**

***b.* Medicaid Eligibility Groups Served in the Waiver.** *Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR 435.217)

	Low income families with children as provided in §1931 of the Act	
X	**SSI recipients**	
	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121	
	Optional State supplement recipients	
	Optional categorically needy aged and/or disabled individuals who have income at: *Select one*:	
		100% of the Federal poverty level (FPL)
		% of FPL, which is lower than 100% of FPL. *Specify percentage*:
	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)	
	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)	
	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)	

	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
	Medically needy in 209(b) States (42 CFR §435.330)
X	**Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
X	**Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)** *Specify*: The federal regulatory criteria for eligibility groups that are covered under the State Medicaid Plan that the state proposes to include under this waiver renewal includes: 42 CFR 435:110 Parents and other caregiver relatives 42 CFR 435:116 Pregnant Women; and 42 CFR 435:118 Children

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Appendix B-5 is not submitted.*
X	***Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.***

Select one and complete Appendix B-5.

	X	**All individuals in the special home and community-based waiver group under 42 CFR §435.217**.		
	X	**Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217** *Check each that applies*:		
		X	**A special income level equal to:** Select one:	
			X	**300% of the SSI Federal Benefit Rate (FBR)**
				A percentage of FBR, which is lower than 300% (42 CFR §435.236) Specify percentage:
				A dollar amount which is lower than 300%.

	Specify dollar amount:
	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
	Medically needy without spend down in 209(b) States (42 CFR §435.330)
	Aged and disabled individuals who have income at: *Select one*:
	100% of FPL
	% of FPL, which is lower than 100%. *Specify percentage amount*:
	Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State **plan that may receive services under this waiver)** *Specify*:

Appendix B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. *Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:*

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

X	**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.* *Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).*
X	**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

	In the case of a participant with a community spouse, the State elects to (select one):	
	X	**Use spousal post-eligibility rules under §1924 of the Act.** *(Complete Item B-5-b (SSI State) and Item B-5-d)*
		Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State) *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*
	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*	

Appendix B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State. *The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income*:

i. Allowance for the needs of the waiver participant (*select one*):

x	**The following standard included under the State plan** *Select one*:		
		SSI standard	
		Optional State supplement standard	
		Medically needy income standard	
	x	**The special income level for institutionalized persons** *(select one):*	
		X	**300% of the SSI Federal Benefit Rate (FBR)**
			A percentage of the FBR, which is less than 300% *Specify the percentage*:
			A dollar amount which is less than 300%. *Specify dollar amount*:
		A percentage of the Federal poverty level *Specify percentage*:	
		Other standard included under the State Plan *Specify*:	

	The following dollar amount *Specify dollar amount*:.
	The following formula is used to determine the needs allowance: *Specify*:
	Other *Specify*:

ii. **Allowance for the spouse only** *(select one):*

X	**Not Applicable**	
	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided: *Specify*:	
	Specify the amount of the allowance (select one):	
		SSI standard
		Optional State supplement standard
		Medically needy income standard
		The following dollar amount: *Specify dollar amount*:
		The amount is determined using the following formula: *Specify*:

iii. Allowance for the family (*select one*):

	Not Applicable (see instructions)
	AFDC need standard
X	**Medically needy income standard**
	The following dollar amount: *Specify dollar amount: ____The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.*
	The amount is determined using the following formula: *Specify*:
	Other

	Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. *Health insurance premiums, deductibles and co-insurance charges*

b. *Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.*

Select one:

	Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
X	**The State does not establish reasonable limits.**
	The State establishes the following reasonable limits *Specify*:

Appendix B-5: Post-Eligibility Treatment of Income (3 of 7)

c. ***Regular Post-Eligibility Treatment of Income: 209(B) State.***

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. ***Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules.*** *The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).*

i. Allowance for the personal needs of the waiver participant

	SSI standard
	Optional State supplement standard
	Medically needy income standard
	The special income level for institutionalized persons
	A percentage of the Federal poverty level

	Specify percentage:
	The following dollar amount: *Specify dollar amount: If this amount changes, this item will be revised*
X	***The following formula is used to determine the needs allowance:*** *Specify formula:* 300% of SSI Standard plus the $20 General Exclusion
	Other *Specify:*

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

X	***Allowance is the same***
	Allowance is different.

Explanation of difference:

iii. ***Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:***

a. *Health insurance premiums, deductibles and co-insurance charges*
b. *Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.*

Select one:

	Not Applicable (see instructions) *Note: If the State protects the maximum amount for the waiver participant, not* *applicable must be selected.*
X	***The State does not establish reasonable limits.***
	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018. *The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).*

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. **Reasonable Indication of Need for Services.** *In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:*

i. **Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

2

ii. **Frequency of services.** *The State requires (select one):*

X	**The provision of waiver services at least monthly**
	Monthly monitoring of the individual when services are furnished on a less than monthly basis
	If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one):*

	Directly by the Medicaid agency
	By the operating agency specified in Appendix A
X	**By an entity under contract with the Medicaid agency.** *Specify*: State University Contract
	Other *Specify*:

c. **Qualifications of Individuals Performing Initial Evaluation:** *Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants*:

Assessors employed through the contracted entity shall have:

1) Master's degree in health or human services from an accredited college or university, OR

2) RN currently licensed as defined in KRS 314.011(5)

d. **Level of Care Criteria.** *Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized*

Participants will be determined by DMS to be eligible for the waiver if the participant:

1) Has medical care needs which can be met in a community-based setting;

2) Meets nursing facility (NF) level of care requirements as defined in [insert KAR];

3) Has service needs which can be met through community based services;

4) Would, without waiver services, be admitted by a physician's order to a NF; and,

5) Meet the target group definitions described in section B-1-a

DMS will utilize clinical documentation and verification to determine level of care. DMS will also utilize the DMS approved functional assessment tool to support development of the Person Centered Service Plan (PCSP) as defined in Appendix D of this waiver application.

e. **Level of Care Instrument(s).** *Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (select one):*

	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
X	**A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**
	Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable. The tool used for institutional care does not reflect the person's community, home or environmental support systems. The criteria used by the waiver to determine the level of care (LOC) better reflects the supports a participant needs to say in their home. The waiver uses level of care (LOC) criteria as specified in [insert KAR]. The determination is made through a review of documentation submitted by the participant at the time of application, including clinical documentation and verification stating the applicant requires institutionalization if they do not receive 1915(c) waiver services and explaining how the applicant's condition affects functional ability. Additionally, applicants may be asked to submit other documents and/or medical records supporting the need for 1915(c) waiver services.

f. **Process for Level of Care Evaluation/Reevaluation:** *Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:*

In order to be considered for 1915(c) waiver services, all applicants must apply using the DMS-approved system and must submit clinical documentation and verification. In addition to stating the applicant would require institutionalization if they did not have 1915(c) waiver services, the clinical documentation and verification must explain how the applicant's specific physical disability or age affects their functional abilities. The applicant may also be required to submit other documents and/or medical records supporting the need for 1915(c) waiver services. Once DMS receives the application, it is evaluated using the following process:

1. The application is reviewed and submitted to all appropriate waiver(s).

2. The application is reviewed for level of care.

3. Once it is determined the applicant meets level of care, DMS reserves capacity for the participant and notifies them to pick a case manager via a letter. The letter includes a phone number for the DMS Waiver Call Center, where the participant can receive assistance in picking a case manager if needed. If there is no open slot in the waiver, the participant is placed on a waiting list until a spot becomes available.

4. After the applicant's spot is reserved, the Department for Community Based Services (DCBS) reviews the applicant's case and determines if they meet financial eligibility requirements for 1915(c) waiver services. For applicants on a waiting list, this financial eligibility determination will not take place until they receive a slot in the waiver. If financial eligibility is denied, the slot is forfeited and the applicant may appeal their financial eligibility determination through DCBS.

5. Once financial eligibility is met, the applicant undergoes a functional assessment conducted by an independent functional assessor. The functional assessment determines the applicant's service needs, which is used to develop the person-centered service plan (PCSP).

For applicants who have been on a waiver waiting list for more than three hundred sixty-five (365) days, new clinical documentation and verification will need to be submitted once a slot is reserved for them on the waiver. Applicants who qualify for multiple waivers can choose to begin services on a waiver with available spots while they are on the waiting list for another waiver. Clinical documentation and verification is not required upon re-evaluation. An independent functional assessment will be conducted yearly to verify the need for continued supports.

g. **Reevaluation Schedule.** *Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (select one):*

	Every three months
	Every six months
X	**Every twelve months**
	Other schedule *Specify the other schedule*:

h. **Qualifications of Individuals Who Perform Reevaluations.** *Specify the qualifications of individuals who perform reevaluations (select one):*

X	**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
	The qualifications are different. *Specify the qualifications*:

i. **Procedures to Ensure Timely Reevaluations.** *Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (specify):*

A task is sent to the functional assessor electronically through the DMS-approved system sixty (60) calendar days prior to the re-evaluation due date. The task remains on the assessor's dashboard until completed or the program is closed.

j. ***Maintenance of Evaluation/Reevaluation Records.*** *Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:*

Copies of evaluations are retained in the DMS approved system until after the participant's termination and then maintained electronically for five (5) years.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. **Procedures.** *Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

All waiver participants are informed of their choice of institutional care or waiver programs and available services by their case manager (CM) or participant-directed case manager (PDCM). This information is provided at the initial person-centered planning meeting and at least annually thereafter. An electronic copy of this signed form is retained in the DMS-approved system.

b. **Maintenance of Forms.** *Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.*

Copies of form are retained in DMS approved system until after the participant's termination and then maintained electronically for five (5) years.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. *Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):*

All Kentucky Medicaid providers are required to provide effective language access services to Medicaid participants who are limited in their English proficiency (LEP). Specific procedures for assuring LEP access may vary by provider, but are required to address assessment of the language needs of participants served by the provider, provision of interpreter services at no cost to the participants, and staff training. Provider procedures for assuring LEP access are ensured through routine interaction and monitoring. When the State learns of a participant needing assistance, staff consult with the participant, case manager and the service provider to determine the type of assistance needed and may require additional activities on the part of the provider to ensure the appropriate translation services are available to the participant.

As indicated in Appendix A, Waiver Administration and Operation, of this application, DMS contracts with several entities to perform some waiver functions. All of these entities are required, through contract, to comply with Federal standards regarding the provision of language services to improve access to their programs and activities for participants who are limited in their English proficiency. Contractors' language services must be consistent with Federal requirements, include a method of identifying LEP-participants, and provide language assistance measures including interpretation and translation, staff training, providing notice to LEP participants, and monitoring compliance and updating procedures.

The Cabinet for Health and Family Services (CHFS) has established a Language Access Section to assist all Cabinet organizational units, including DMS, in effectively communicating with LEP participants, as well as complying with Federal requirements. The Language Access Section has qualified interpreters on staff, maintains a listing of qualified interpreters for use by CHFS units and contractors throughout the state, contracts with a telephone interpretation service for use by CHFS units and contractors when appropriate, provides translation services for essential program forms and documents, establishes policies and procedures applicable to CHFS, and provides technical assistance to CHFS units as needed. Procedures employed by individual departments and units (i.e. DMS) include posting multi-lingual signs in waiting areas to explain that interpreters will be provided at no cost; using "I Speak" cards or a telephone language identification service to help identify the primary language of LEP participants at first contact; recording the primary language of each LEP individual served; providing interpretation services at no cost to the participant served; staff training; and monitoring of staff offices and contractors.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

a. **Methods for Discovery:**

Methods for Discovery:	*The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD*					
Sub-assurance:	*An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*					
Performance measure:	Percent of new enrollees who had a level of care evaluation indicating need for institutional level of care prior to receipt of services. N= Number of new enrollees who had a level of care indicating need for institutional level of care prior to receipt of services. D= Number of new waiver participants					
Data Source: Waiver enrollment data						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify:* Delegated Entities	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other*

						Specify:
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD*
Sub-assurance:	*An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*
Performance measure:	Percent of waiver participants who received a redetermination of level of care within 12 months of their initial or last level of care determination. N= The number of waiver participants who received a redetermination of level of care. D= The number of waiver participants who should have received a redetermination of level of care determination.

Data Source: Waiver enrollment data						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval:95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify:* Delegated Entities	X	*Annually*		*Stratified.* *Describe Group:*

				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD*
Sub-assurance:	*The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care*
Performance measure:	Percent of waiver participants reviewed by delegated entity whose initial or subsequent level of care was appropriately determined as required by the state. N= Number of randomly selected waiver participants whose level of care was done appropriately. D= Total number of levels of care reviewed.

Data Source: Level of care documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other*	X	*Annually*		*Stratified.* *Describe Group:*

		Specify: Delegated Entities				
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible*.

Assessment services include a comprehensive initial functional assessment which shall be conducted by the Independent Assessor within the appropriate calendar days of receipt of the request for the assessment. DMS receives monthly reports that note when waiver participants are transitioning into the state's Managed Care Option. This would indicate to DMS that the participant's waiver information may be incorrect or incomplete. DMS will also receive a monthly report of reassessments that were not completed within the appropriate period to allow for identification of issues.

b. Method for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items*.

DMS addresses problems as discovered through the generated reports noted above. The Division of Community Alternatives will review the reports and provide remediation activities as needed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
X	*State Medicaid Agency*		*Weekly*

	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
	Other *Specify:*	X	*Annually*
			Continuously and Ongoing
			Other *Specify:*

c. Timeline
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

X	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation*.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary**. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c.

Service Type	Service
Statutory Service	Adult Day Health
Statutory Service	Case Management
Other Service	Personal Assistance
Other Service	Home and Community Supports
Other Service	Environmental and Minor Home Modifications
Other Service	Goods and Services
Other Service	Home Delivered Meals
Statutory Service	Non-specialized Respite
Statutory Service	Specialized Respite
Other Service	Participant Directed Case Management

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C-1/C-3: Service Specification

Service Type:	Other Service			
Service Name:	Personal Assistance			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	08 Home Based Services	**Sub-Category 1:**	08030 personal care
	Category 2:		**Sub-Category 3:**	
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Personal assistance services enable waiver participants to accomplish tasks that they normally would do for themselves if they did not have a disability. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments and accompanying the waiver participant during medical appointments. Transportation to access community services, activities and appointments shall not duplicate State plan transportation services. Personal assistance services take place in the waiver participant's home, and in the community as appropriate to the individual's need. Personal assistance services are available only to a waiver participant who lives in his /her own residence or in his/her family residence. Personal assistance services are not available to individuals under the age of 21 when medically necessary personal assistance services are covered by EPSDT. Personal			

	assistance services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	Unit of service: 15 minutes One hundred eighty (180) units per week in combination with day services. This service cannot be billed concurrently with other services.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)***:**		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Home Health Agency
Agency	Adult Day Health Care Agency

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Home Health Agency	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:081
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in 907 KAR7:005. Agency staff who come into direct contact with waiver participants must meet the following qualifications: • At least eighteen (18) years of age. • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking. • Has the ability to: o Communicate effectively with a participant in the participant's preferred

		manner of communication and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Participate as a member of the participant's person centered team if requested by the participant; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years annually thereafter

Provider Specification		
Provider Category:	Agency	
Provider Type:	Adult Day Health Care Agency	
Provider Qualifications:	**License** *(specify):*	902 KAR 20:066
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in 907 KAR7:005. Agency staff who come into direct contact with waiver participants must meet the

		following qualifications: • At least eighteen (18) years of age. • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking. • Has the ability to: o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Participate as a member of the participant's person centered team if requested by the participant; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years thereafter

C-1/C-3: Service Specification

Service Type:	Other Service			
Service Name:	Home and Community Supports			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	08 Home Based Services	**Sub-Category 1:**	08030 personal care
	Category 2:	08 Home Based Services	**Sub-Category 3:**	08050 homemaker
	Category 3:	08 Home Based Services	**Sub-Category 3:**	08040 companion
	Category 4:	15 Non-medical transportation	**Sub-Category 4:**	15010 non-medical transportation
Service Definition *(Scope)*:	Home and community supports enable waiver participants who elect to utilize participant directed services to accomplish tasks that they normally would do for themselves if they did not have a disability and would not be typically provided by natural supports. This assistance may include hands-on assistance (actually performing a task for the person), reminding, observing, guiding, and/or training a waiver participant in ADLs (such as bathing, dressing, toileting, transferring, maintaining continence) and IADLs (more complex life activities such as personal hygiene, light housework, laundry, meal planning and preparation, transportation, grocery shopping, using the telephone, money management, and medication administration). This service may also include assisting the waiver participant in managing his/her medical care including making medical appointments, and accompanying the waiver participant during medical appointments. Transportation to access community services, activities and appointments shall not duplicate State plan transportation services. Home and Community Supports take place in the waiver participant's home, and in the community as appropriate to the individual's need. Home and community supports are available only to a waiver participant who lives in his /her own residence or in his/her family residence.			

	Home and Community Supports services are not available to participants under the age of 21. When medically necessary and available as a service, personal assistance services are covered by EPSDT for these participants. Personal assistance services may not supplant educational services available under the IDEA (20 U.S.C. 1401 et seq.).	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	One hundred eighty (180) units per week in combination with day services. One unit is equal to fifteen (15) minutes. This service cannot be billed concurrently with other services.	
Service Delivery Method:	**X**	**Participant-directed as specified in Appendix E**
		Provider managed
Specify whether the service may be provided by *(check each that applies)***:**	**X**	**Legally Responsible Person**
	X	**Relative**
	X	**Legal Guardian**

Provider Specifications:	
Provider Category	**Provider Type Title**
Individual	Qualified Participant Approved Provider

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Individual	
Provider Type:	Qualified Participant Approved Provider	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	
	Other Standard *(specify):*	The individual must meet the following qualifications to deliver the service: • At least eighteen (18) years of age. • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, professional boundaries, trauma-informed care, and person-centered thinking. • Has the ability to: o Communicate effectively with a participant in the participant's

		preferred manner of communication and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Participate as a member of the participant's person centered team if requested by the participant; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	Case Manager/Participant-Directed Case Manager (PDCM)
	Frequency of Verification:	Prior to service delivery and as required based on DMS or its designee's requirements.

C-1/C-3: Service Specification

Service Type:	Statutory Service			
Service Name:	Case Management			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**		**Sub-Category 1:**	
	Category 2:		**Sub-Category 3:**	

	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Case management activities include assisting participants in gaining access to waiver services and other needed services through the Medicaid state plan and other non-Medicaid funded community-based programs to support the participant's home and community-based needs. Case management involves working with the participant, the participant's guardian, and/or their authorized representative and others who the participant identifies, such as family member(s), in developing a Person-Centered Service Plan (PCSP). Using a person-centered planning process, case management assists in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs, using waiver-funded and non-waiver funded services. Support strategies incorporate: the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. Case managers adhere to person-centered principles during all planning, coordination, and monitoring activities. Case managers work closely with the participant to assess his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. Case managers assure that participants have freedom of choice of providers in a conflict-free environment. Case management must be conflict-free and the case manager or its agency cannot provide other waiver services to the participant while also providing case management. Conflict-free case management, as stipulated in the Affordable Care Act and Federal Final Rule CMS 2249F, requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to a participant must not also provide another waiver service to that same participant, unless the servicing provider and case manager are the only willing and qualified providers in the geographical area (30 miles from the participant's residence). When one entity is responsible for providing case management and service delivery, appropriate safeguards and firewalls must exist to mitigate risk of potential conflict.			

	Case management activities include face-to-face, telephonic, and other methods of communication to provide coordination and oversight, which assure the following: • Provision of education to support participant's service delivery model selection between traditional, participant-directed services (PDS), and blended services; • Conflict-free options counseling to select appropriate services to meet identified needs and HCBS goals, along with education about available HCBS service providers; • The facilitation of participant-driven self-assessment and PCSP development; • The desires and needs of the participant are determined through a person-centered planning process; • The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives; • The coordination of multiple services and/or among multiple providers; • Linking waiver participants to services that support their home and community-based needs; • Monitoring the implementation of the PCSP, participant health and welfare, and service improvement plans (SIP) for participants; • Addressing problems in service provision; • Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis; • Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services; and, • Developing and accessing social networks to promote community inclusion as requested by the participant. Activities are documented, and plans for supports and services are reviewed by the case manager at least annually and more often as needed using the person-centered planning processes described in Appendix D.
Specify applicable (if any) limits on the amount,	Case management is limited to one (1) monthly unit per participant per provider per month.

frequency, or duration of this service:	The Department for Medicaid Services may approve additional units if deemed appropriate.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)*:		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Certified Waiver Case Management Agency

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Certified Waiver Case Management Agency	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR here]. Agency case management staff who come into direct contact with waiver participants must meet the following qualifications: • Have a bachelor's degree in one of the following fields: ○ Psychology, behavioral analysis, counseling, rehabilitation counseling, public health, special education, sociology, gerontology, recreational therapy, education, occupational therapy, physical therapy, speech-language pathology, social, or family studies, OR • A bachelor's degree from an accredited college or university with

		one (1) year of experience working with the aged and/or physically disabled population, OR • Be a registered nurse (RN) currently licensed in Kentucky as defined in KRS 314.011(5) • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking. • Completes DMS-approved case management training. • Has the ability to: o Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Facilitate the participant's person-centered team; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.

Verification of Provider Qualifications:	**Entity Responsible for Verification:**	DMS or its designee
	Frequency of Verification:	Initially and every two (2) years or more frequently if necessary

C-1/C-3: Service Specification

Service Type:	Statutory Service			
Service Name:	Adult Day Health			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	04 Day Services	**Sub-Category 1:**	04060 adult day services (social model)
	Category 2:		**Sub-Category 3:**	
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Adult day health care (ADHC) services must include basic and ancillary services for waiver participants who are eighteen (18) years or older. ADHC services are given in accordance with 902 KAR 20:066 operations and services; adult day health care programs. Basic services may include skilled nursing services, one or more meals per day but do not constitute a full nutritional regimen (i.e. three full meals per day), snacks, RN supervision, regularly scheduled daily activities, crisis service, routine personal and healthcare needs and equipment essential to the provision of the ADHC services. When a participant is receiving ADHC services, all personal care needs should be addressed within that service. ADHC services must be approved by DMS or its designee prior to service delivery.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	One hundred eighty (180) units per week in combination with day services. One unit equals fifteen (15) minutes.			

	This service cannot be billed concurrently with other services.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)***:**		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Adult Day Health Center

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Adult Day Health Center	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:066
	Certificate *(specify):*	Certified by DMS or its designee

	0Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR here].
		
		The agency must employ staff with the following qualifications to deliver the service:
		
		• At least eighteen (18) years of age.
		• Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant and the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and

		○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP) • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and every two (2) years or more frequently if necessary

C-1/C-3: Service Specification

Service Type:	Other Service			
Service Name:	Home Delivered Meals			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**		**Sub-Category 1:**	
	Category 2:		**Sub-Category 3:**	
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Home delivered meals service is defined as the provision of meals to a waiver participant who has a need for a home delivered meal. This is based on a deficit related to meal preparation in activities of daily living (ADL) or instrumental activities of daily living (IADL) identified during the functional assessment process. The service includes the preparation, packaging, and delivery of safe and nutritious meals to a participant at his or her home. Meals may be hot, shelf stable, or frozen as determined by the participant's PCSP. Home delivered meals shall: 1. Be provided to participants who are unable or find it functionally challenging to prepare their own meals based on			

	the results of the functional assessment and for whom there are no other persons available to do so. 2. Take into consideration the participant's medical restrictions, religious, cultural and ethnic background, and dietary preferences. 3. Be individually packaged. 4. Meet participant's nutritional needs. 5. Be consumed by the participant. Home delivered meals shall not: 1. Include bulk ingredients, liquids, and other food used to prepare meals independently or with assistance. 2. Include nutritional supplements such as Ensure, Boost, or any physician prescribed dietary supplements administered via G-tube or other feeding mechanism. 3. Be provided while the participant is hospitalized or residing in an institutional setting. 4. Duplicate service provided through other programs funded or operated by the Department for Aging and Independent Living (DAIL), community feeding program, or any other governmental agency. 5. Be limited to hot meals. Shelf-stable or frozen meals may be allowed as well.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	A participant may receive up to one (1) meal each day.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)*:		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Certified Waiver Meal Provider

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Certified Waiver Meal Provider	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee

	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR here]. All home delivered meals providers shall meet the definition of a food establishment in Kentucky according to the Food Establishment Act and State Retail Food Code 902 KAR 45:005 and KRS 217.015. All providers must follow regulations and procedures outlined in the above statute also known as the Kentucky Food Code. Providers must: 1) Have all permits and conform to applicable laws and regulations under the Kentucky Food Code; 2) Deliver meals in accordance with the person centered service plan (PCSP), in a sanitary manner, and at the correct temperature for the specific type of food; 3) Provide meals which contain at least 1/3 of the recommended daily allowance per meal and meet the requirements of the Dietary Guidelines for Americans. Menus must be certified in writing by a Licensed Dietician as meeting those criteria; 4) Allow federal, state, and local agency staff to monitor for compliance. Agency staff who come into direct contact with waiver participants must meet the following qualifications: • At least eighteen (18) years of age. • Has the ability to: ○ Communicate effectively with a participant in the participant's preferred manner of communication

		and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Participate as a member of the participant's person-centered team if requested by the participant; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is legally licensed to operate the transporting vehicle to which the individual is assigned or owns, and has proof of current liability insurance for the vehicle in which the participant is transported.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	DMS or its designee
	Frequency of Verification:	Initially and two (2) years or more frequently if necessary

C-1/C-3: Service Specification

Service Type:	Other Services			
Service Name:	Environmental and Minor Home Modifications Needs			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	14 Equipment, Technology, and Modifications	**Sub-Category 1:**	14020 home and/or vehicle accessibility adaptations
	Category 2:		**Sub-Category 3:**	

	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Structural and/or permanent environmental and minor home modifications are only for the privately-owned residence of the participant or the participant's family owned home in which he/she resides. Physical adaptations to the home, required by the participant's person-centered service plan (PCSP), are necessary to ensure the health, safety, and welfare of the participant, or to enable the participant to function with greater independence in the home, without which, the participant would be at risk for institutionalization. Adaptations to rental properties must be portable. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities for accessibility, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant. This service excludes adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, such as roof repair, central air conditioning/heating, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. This service will not include repair of previous damage, routine home maintenance, cosmetic improvements, or unnecessary repairs. The agency must ensure the adaptations are completed by an agency that is licensed to provide these services, is a registered business, and is in good standing with the Kentucky Secretary of State. Environmental and minor home modification services must be approved by DMS or its designee prior to service delivery.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	$10,000 lifetime limit			
Service Delivery Method:		**Participant-directed as specified in Appendix E**		
	X	**Provider managed**		

Specify whether the service may be provided by *(check each that applies)***:**		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Individual	Service Vendor
Agency	Service Vendor

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Individual	
Provider Type:	Service Vendor	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The individual is licensed to provide the good or service, is a registered business, and is in good standing with the Kentucky Secretary of State.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	Case Manager/PDCM
	Frequency of Verification:	Prior to service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Service Vendor	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency is licensed to provide the good or service, is a registered

		business, and is in good standing with the Kentucky Secretary of State.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	Case Manager/PDCM
	Frequency of Verification:	Prior to service

C-1/C-3: Service Specification

Service Type:	Other Services			
Service Name:	Goods and Services			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	17 Other services	**Sub-Category 1:**	17010 goods and services
	Category 2:		**Sub-Category 3:**	
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Individual goods and services are services and supplies not otherwise provided through other services under this waiver, state plan services, or other resources. Goods and services include: Bathing & Hygiene Aids Dental Work Dining Aids Durable Medical Equipment items denied by state plan due to limitations in fee schedule Glasses Hearing Aids Household Kitchen Aids Incontinence Supplies for participants older than three (3) years of age Medication Aids Nutritional Supplements for increased caloric or nutritional needs (Excludes any other vitamins, supplements, or alternative forms of nutrition)			

	Weighted Blankets Does not include: Experimental goods or services, chemical and physical restraints, or over the counter medications or vitamins. Other medically necessary items can be reviewed for approval on a case-by-case basis. DMS will utilize existing fee schedules to determine the cost effectiveness of covered goods and services. Goods and services address an identified need in the person-centered service plan (PCSP) and are targeted to the participant's disability. Goods and services will only be covered under the waiver if the item is deemed necessary to ensure health, safety, and welfare in the community but is otherwise not covered by state plan. Request for goods and services must include documentation of need from a doctor, physician's assistant (PA), advanced registered nurse practitioner (ARPN), or a licensed clinical therapist. In order to be covered, items must meet regulatory criteria. For all waiver participants younger than 21 years of age, goods and services must be provided under the Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and will not be covered through this waiver service.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	One thousand five hundred dollars ($1,500) per LOC year -- Any one item more than five hundred dollars ($500) must be approved by DMS or its designee prior to service delivery.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)***:**		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Service Vendor

C-1/C-3: Provider Specifications for Service

Provider Specification	
Provider Category:	Agency

Provider Type:	Service Vendor	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency is licensed to provide the good or service, is a registered business, and is in good standing with the Kentucky Secretary of State.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	Case Manager/PDCM
	Frequency of Verification:	Prior to service

C-1/C-3: Service Specification

Service Type:	Statutory Service			
Service Name:	Non-specialized Respite			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**	09 Caregiver Support	**Sub-Category 1:**	09012 respite, in-home
	Category 2:	09 Caregiver Support	**Sub-Category 3:**	09011 respite, out-of-home
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Non-specialized respite care is short-term care due to an absence or need for relief of the primary, unpaid caregiver and be utilized for participants who are unable to independently manage or execute self-care. Non-specialized respite care services should be provided in accordance with goals established during person-centered service plan development. Non-specialized respite care shall address individualized self-care, safety, positive social impact and recreational needs, and			

	supervision needs. Non-specialized respite care services must be provided at a level to appropriately and safely meet the needs of the participant including continual monitoring and supervision. Receipt of respite care does not preclude a participant from receiving other services on the same day if the other services are not provided concurrently. Participants accessing residential services cannot receive respite care. A residential provider may provide respite services to participants (as long as they do not reside at the residential site) facility) but may not use another person's bedroom or another person's belongings in order to provide respite care for a different person. Non-specialized respite may be provided in the participant's residence.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	Four thousand dollars ($4,000) per LOC year in combination with Specialized Respite. Respite cannot be billed concurrently with other services.	
Service Delivery Method:	**X**	**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)*:		**Legally Responsible Person**
	X	**Relative**
		Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Qualified Participant Approved Provider
Agency	Adult Day Health Center
Agency	Home Health Agency
Agency	Certified Waiver Agency
Agency	Community Mental Health Center

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Individual	
Provider Type:	Qualified Participant Approved Provider	
Provider Qualifications:	**License** *(specify):*	

	Certificate *(specify):*	

	Other Standard *(specify):*	The individual must meet the following qualifications:
		
		• At least eighteen (18) years of age.
		• Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, professional boundaries, trauma-informed care, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and
		  ○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).
		
		• • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.

Verification of Provider Qualifications:	**Entity Responsible for Verification:**	Case Manager/Participant Directed Case Manager

	Frequency of Verification:	Prior to service delivery and as required based on DMS or its designee's requirements.

Provider Specification		
Provider Category:	Agency	
Provider Type:	Adult Day Health Center	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:066
	Certificate *(specify):*	Certified by DMS or its designee

	0Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR here].
		
		The agency must employ staff with the following qualifications to deliver this service:
		
		• At least eighteen (18) years of age.
		• Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant and the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and
		  ○ Demonstrate competence and knowledge of topics

		required to safely support the participant as described in the participant's person-centered service plan (PCSP) • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid. • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle. •
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years or more frequently if necessary

Provider Specification		
Provider Category:	Agency	
Provider Type:	Home Health Agency	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:081
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR]. The agency must employ staff with the following qualifications to deliver this service: • At least eighteen (18) years of age. • Completes DMS-approved, waiver-specific training yearly on topics

		including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant and the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and
		  ○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP)
		• Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
		• Is certified in CPR and First Aid.
		• If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.

Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years or more frequently if necessary

Provider Specification

Provider Category:	Agency	
Provider Type:	Community Mental Health Center	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:091
	Certificate *(specify):*	Certified by DMS

	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in 907 KAR7:005.
		
		The agency must employ staff with the following qualifications to deliver this service:
		
		• At least eighteen (18) years of age.
		• Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant and the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and
		  ○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP)

		• Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid. • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years or more frequently if necessary

Provider Specification		
Provider Category:	Agency	
Provider Type:	Certified Waiver Agency	
Provider Qualifications:	**License** *(specify):*	
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR]. Agency staff who come into direct contact with waiver participants must meet the following qualifications: • At least eighteen (18) years of age. • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking. • Has the ability to:

		○ Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family; ○ Read, understand, and implement written and oral instructions; ○ Perform required documentation; ○ Participate as a member of the participant's person-centered team if requested by the participant; and ○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid. • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years or more frequently if necessary

C-1/C-3: Service Specification

Service Type:	Statutory Service
Service Name:	Specialized Respite
Alternative Service Title (if any):	

HCBS Taxonomy:	**Category 1:**	09 Caregiver Support	**Sub-Category 1:**	09012 respite, in-home
	Category 2:	09 Caregiver Support	**Sub-Category 3:**	09011 respite, out-of-home
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Specialized Respite services are defined as short-term care provided to a waiver participant to address the need for relief of or the emergent absence or illness of the participant's primary caregiver. Specialized respite services direct care staff must have 24-hour access to a registered nurse for consultation and emergency situations. Specialized respite services cannot be utilized to provide respite to a paid caregiver, including participant-directed employees. Services must be provided at a level to appropriately and safely meet the support needs of the waiver participant and that the respite provider has the appropriate training and qualifications. To qualify for specialized respite the participant must need skilled care during the time when specialized respite is to be provided. Skilled services that would qualify a participant for specialized respite include: 1) IV Medications, fluids or IV-line flushes, PIC line and dressing changes; 2) Medication Administration (not IV); 3) Ostomy-related SKILLED Services; 4) Oxygen and/or Respiratory Treatments)—tracheal suctioning, C-PAP, Bi-PAP, nebulizers, IPPB treatments (does NOT include inhalers); 5) Peritoneal Dialysis; 6) Total Parenteral Nutrition; 7) Tracheostomy care; 8) Tube Feedings; 9) Dressing changes for a pressure ulcer stage 2, 3, or 4; 10) Urinary Catheter-related skilled tasks (irrigation, straight catheterizations);			

	11) Skilled Wound Care; 12) Ventilator-related interventions; or, 13) A current health instability that requires skilled nursing assessment and interventions and involves changes in the medical treatment or nursing care plan, as noted on the functional assessment. Specialized respite services shall only be provided by licensed home health agencies or adult day health care agencies and can be provided in the following locations: (a) The home of the participant; (b) An adult day health care center licensed by the state of Kentucky; or, Registered nurses and licensed practical nurses must perform duties within their scope as defined by their licensure. Specialized respite services must be approved by DMS or its designee prior to service delivery.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	Four thousand dollars ($4,000) per LOC year in combination with Non-Specialized Respite. Respite cannot be billed concurrently with other services.	
Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)***:**		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Adult Day Health Center

C-1/C-3: Provider Specifications for Service

Provider Specification	
Provider Category:	Agency
Provider Type:	Adult Day Health Center

Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:066
	Certificate *(specify):*	Certified by DMS or its designee

	0Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR].
		Agency staff who come into direct contact with waiver participants must meet the following qualifications:
		• Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking.
		• Has the ability to:
		  ○ Communicate effectively with a participant in the participant's preferred manner of communication and with the participant's family;
		  ○ Read, understand, and implement written and oral instructions;
		  ○ Perform required documentation;
		  ○ Participate as a member of the participant's person-centered team if requested by the participant; and
		  ○ Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP).
		• Undergoes pre-employment screenings as described in C-2.a and b of this appendix.
		• Is certified in CPR and First Aid.

		• If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and at least every two (2) years or more frequently if necessary

Provider Specification		
Provider Category:	Agency	
Provider Type:	Home Health Agency	
Provider Qualifications:	**License** *(specify):*	By OIG 902 KAR 20:081
	Certificate *(specify):*	Certified by DMS or its designee
	0Other Standard *(specify):*	The agency must meet certified waiver provider qualifications as defined in [insert KAR]. Agency staff who come into direct contact with waiver participants must meet the following qualifications: • Completes DMS-approved, waiver-specific training yearly on topics including, but not limited to: abuse, neglect, exploitation and incident reporting, medication administration, professional boundaries, trauma-informed care, and person-centered thinking. • Has the ability to: ○ Communicate effectively with a participant in the participant's preferred manner of communication

		and with the participant's family; o Read, understand, and implement written and oral instructions; o Perform required documentation; o Participate as a member of the participant's person-centered team if requested by the participant; and o Demonstrate competence and knowledge of topics required to safely support the participant as described in the participant's person-centered service plan (PCSP). • Undergoes pre-employment screenings as described in C-2.a and b of this appendix. • Is certified in CPR and First Aid. • If the employee provides transportation, the employee must be legally licensed to operate the transporting vehicle and obeys all applicable state laws while operating the vehicle.
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially or at least every two (2) years or more frequently if necessary

C-1/C-3: Service Specification

Service Type:	Statutory Service			
Service Name:	Participant Directed Case Management			
Alternative Service Title (if any):				
HCBS Taxonomy:	**Category 1:**		**Sub-Category 1:**	

	Category 2:		**Sub-Category 3:**	
	Category 3:		**Sub-Category 3:**	
	Category 4:		**Sub-Category 4:**	
Service Definition *(Scope)*:	Participant directed case management activities include assisting participants in gaining access to waiver services and other needed services through the Medicaid state plan and other non-Medicaid funded community-based programs to support the participant's home and community-based needs. Participant directed case management involves working with the participant, the participant's guardian, and/or their authorized representative and others who the participant identifies, such as family member(s), in developing a Person-Centered Service Plan (PCSP). Using a person-centered planning process, participant directed case management assists in identifying and implementing support strategies to enable the PCSP to advance the participant's identified goals while meeting assessed community-based needs, using waiver-funded and non-waiver funded services. Support strategies incorporate: the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. Participant directed case managers adhere to person-centered principles during all planning, coordination, and monitoring activities. Participant directed case managers work closely with the participant to assess his or her ongoing expectations and satisfaction with their lives in the community, the processes and outcomes of supports, services, and available resources. Participant directed case managers assure that participants have freedom of choice of providers in a conflict-free environment. Participant directed case management must be conflict-free and the participant directed case manager or its agency cannot provide other waiver services to the participant while also providing participant directed case management. Conflict-free case management, as stipulated in the Affordable Care Act and Federal Final Rule CMS 2249F, requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to a participant must not also provide another waiver service to that same participant, unless the servicing provider and participant directed case management are the only willing and qualified providers in the geographical area (30 miles from the			

	participant's residence). When one entity is responsible for providing participant directed case management and service delivery, appropriate safeguards and firewalls must exist to mitigate risk of potential conflict. Participant directed case management activities include face-to-face, telephonic, and other methods of communication to provide coordination and oversight, which assure the following: • Provision of education to support participant's service delivery model selection between traditional, participant-directed services (PDS), and blended services; • Conflict-free options counseling to select appropriate services to meet identified needs and HCBS goals, along with education about available HCBS service providers; • The facilitation of participant-driven self-assessment and PCSP development; • The desires and needs of the participant are determined through a person-centered planning process; • The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives; • The coordination of multiple services and/or among multiple providers; • Linking waiver participants to services that support their home and community-based needs; • Monitoring the implementation of the PCSP, participant health and welfare, and service improvement plans (SIP) for participants; • Addressing problems in service provision; • Implementing participant crisis mitigation plans and making appropriate referrals to address active or potential crisis; • Detecting, reporting, and mitigating suspected abuse, neglect, and exploitation of participants, including adherence to mandatory reporter laws, and monitoring the quality of the supports and services; and, • Developing and accessing social networks to promote community inclusion as requested by the participant. Activities are documented, and plans for supports and services are reviewed by the participant directed case manager at least annually and more often as needed using the person-centered planning processes described in Appendix D.

	Participant directed case managers have a role in monitoring and assisting participants who choose to self-direct their services. Appendix E describes the waiver's participant self-direction program. Case managers of participants who choose to self-direct are known as Participant-Directed Case Managers (PDCM) and have the following responsibilities, in addition to those listed above in this definition: • Facilitate self-assessment of participant's support needs related to employer authority; • Arrange or provide necessary support to participants as identified in the self-assessment, to offer needed assistance to execute employer authority; • Monitor the participant's execution of budget and/or employer authority and document any identified risks, challenges, and outcomes; • The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives; • Support selection and provide on-going coordination between the participant and the chosen participant directed case management agency; and, • Monitoring of corrective action plans (CAP) for PDS employees. The provider shall perform the employer responsibilities of payroll processing which shall include: issuance of paychecks; withholding federal, state and local tax and making tax payments to the appropriate tax authorities; and, issuance of W-2 forms. The provider shall be responsible for performing all fiscal accounting procedures including issuance of expenditure reports to the participant, their representative, the case manager and the Department for Medicaid Services. The provider shall maintain a separate account for each participant while continually tracking and reporting funds, disbursements and the balance of the member′s budget. The provider shall process and pay invoices for goods and services approved in the participant′s PCSP. FMS is required for participants that elect the participant directed services model.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	Up to two (2) units per month

Service Delivery Method:		**Participant-directed as specified in Appendix E**
	X	**Provider managed**
Specify whether the service may be provided by *(check each that applies)*:		**Legally Responsible Person**
		Relative
		Legal Guardian

Provider Specifications:	
Provider Category	**Provider Type Title**
Agency	Community Mental Health Center
Agency	Area Agency on Aging

C-1/C-3: Provider Specifications for Service

Provider Specification		
Provider Category:	Agency	
Provider Type:	Community Mental Health Centers	
Provider Qualifications:	**License** *(specify):*	902 KAR 20:091
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	Community Mental Health Centers and Area Development Districts are quasi-governmental agencies operating throughout the Commonwealth of Kentucky. Both organizations were established by state law, specifying the manner of governance, organization, staffing and areas of responsibility (KRS 210.370 to 210.480 CMHCs; and KRS 147A.050 to 147A.110 Area Development Districts.) Both CMHCs and Area Development Districts have a designated region within the state to which their services are mandated and limited. To provide Medicaid waiver services, quasi-governmental agencies must be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulations, receive training approved by the Department for Medicaid Services on financial management responsibilities and be subject to regular oversight and monitoring, including on-site monitoring, by the Department for Medicaid Services.

		All standards identified in program regulations and services manual
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and every two years or more frequently if necessary

Provider Specification		
Provider Category:	Agency	
Provider Type:	Area Agencies on Aging (AAA)	
Provider Qualifications:	**License** *(specify):*	902 KAR 20:091
	Certificate *(specify):*	Certified by DMS or its designee
	Other Standard *(specify):*	Community Mental Health Centers and Area Development Districts are quasi-governmental agencies operating throughout the Commonwealth of Kentucky. Both organizations were established by state law, specifying the manner of governance, organization, staffing and areas of responsibility (KRS 210.370 to 210.480 CMHCs; and KRS 147A.050 to 147A.110 Area Development Districts.) Both CMHCs and Area Development Districts have a designated region within the state to which their services are mandated and limited. To provide Medicaid waiver services, quasi-governmental agencies must be enrolled as a Kentucky Medicaid provider in accordance with Kentucky regulations, receive training approved by the Department for Medicaid Services on financial management responsibilities and be subject to regular oversight and monitoring, including on-site monitoring, by the Department for Medicaid Services.

		All standards identified in program regulations and services manual
Verification of Provider Qualifications:	**Entity Responsible for Verification:**	OIG DMS or its designee
	Frequency of Verification:	Initially and every two years or more frequently if necessary

C-1/C-3: Provider Specifications for Service

C-1: Summary of Services Covered (2 of 2)

b. **Provision of Case Management Services to Waiver Participants**. *Indicate how case management is furnished to waiver participants (select one):*

	Not applicable – *Case management is not furnished as a distinct activity to waiver participants*.	
X	**Applicable** – *Case management is furnished as a distinct activity to waiver participants*. *Check each that applies*:	
	X	**As a waiver service defined in Appendix C-3**. Do not complete item C-1-c.
		As a Medicaid State plan service under 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
		As a Medicaid State plan service under 1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
		As an administrative activity. *Complete item C-1-c.*

c. **Delivery of Case Management Services**. *Specify the entity or entities that conduct case management functions on behalf of waiver participants*:

As indicated in C-1-b, this section is not applicable.

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations**. *Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):*

	No. Criminal history and/or background investigations are not required.
X	***Yes. Criminal history and/or background investigations are required.***

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

A. All providers or provider agency employees with contact with participants are required to undergo a background investigation at hiring and repeated as appropriate.

B. Kentucky offers employers two options for conducting pre-employment background investigations.

   i. The Kentucky Applicant Registry and Employment Screening (KARES) system: KARES is an electronic interface and nationwide background investigation and registry system. KARES enables automatic abuse registry checks, including continuous assessment (i.e. ongoing

registry checks after employment date), as well as fingerprint-based background checks through Kentucky State Police (KSP) and the Federal Bureau of Investigation (FBI).

ii. If KARES is not used, pre-employment background investigations must be conducted using all four (4) of the following:

1. Administrative Office of the Courts (AOC) Background Check operated by Kentucky Court of Justice and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment
2. Kentucky Child Abuse and Neglect (CAN) Registry operated by the Cabinet for Health and Family Services and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment
3. Caregiver Misconduct Registry operated by the Cabinet for Health and Family Services
4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing.

If a potential employee has resided or worked out of state within the last 12 calendar months the other state's equivalency of all checks must completed and results provided for that timeframe.

C. All employees, including agency and PDS employees with contact with participants, are also required to pass a six-panel drug screening prior to employment.

D. Provider agencies are responsible for conducting pre-employment background screenings on agency employees. The following disqualifies an agency employee from providing services:

1. A prior conviction for an offense as described in KRS 17.165(1) through (3)
2. A prior felony conviction or diversion program that has not been completed
3. A drug conviction, felony plea bargain, or amended plea bargain within the past five (5) years
4. Employees with a drug related conviction or an amended plea bargain within the past five (5) years must prove completion of all court ordered treatment and/or diversional programs. The employing provider agency must conduct a random, six-panel drug screening within the following frequency depending on the timeframe since conviction:
    a. Every ninety (90) days for employees who are three (3) years or less removed from his/her conviction or
    b. Every one-hundred eighty (180) days for employees three (3) to five (5) years removed from his/her conviction.
    c. Random drug screenings are not required for employees who are over five (5) years removed from his/her conviction.
5. Failing to pass a six-panel drug test
6. Has a conviction for abuse, neglect, or exploitation (ANE) as defined in Appendix G
7. Has substantiated finding of abuse, neglect or exploitation through adult protective services (APS) or child protective services (CPS)
8. Prior substantiated case of Medicaid fraud by the Medicaid Fraud Control Unit (MFCU), OIG or OAG.
9. Employees who have a driving under the influence conviction, amended plea bargain, or diversion in the past year shall not transport participants

E. DMS requires pre-employment background investigations for PDS employees. With the assistance of their participant-directed case manager (PDCM), participants obtain and review the background investigation of their potential employee. It is the participant's responsibility, with assistance from the PDCM to determine if an individual is appropriate to provide services. If the

individual meets criteria for exclusion by an agency as listed above, the participant must sign a form acknowledging they are aware of the individual's background and consent to having them provide services anyway. Although participants have the choice to hire employees with disqualifying events on their record, DMS does not allow for the following events to be excused:

1. A conviction for abuse, neglect, or exploitation (ANE) as defined in Appendix G
2. A substantiated finding of abuse, neglect or exploitation through adult protective services (APS), or child protective services (CPS).
3. A Prior substantiated case of Medicaid fraud by the Medicaid Fraud Control Unit (MFCU), OIG or OAG.
4. A prior conviction for an offense as described in KRS 17.165(1) through (3)

F. The participant, as the employer, is responsible to ensure the potential hire meets qualifications. The cost of obtaining criminal background checks, drug testing and all costs associated with securing employment may be covered by the employee, employer or other interested third parties, such as family members, friends, churches, local community organizations, etc.

G. All employees, agency or PDS, must also undergo a screening for tuberculosis per Department of Health guidelines.

b. **Abuse Registry Screening.** *Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):*

	No. The State does not conduct abuse registry screening.
X	**Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

All employees of traditional service providers with contact with the participant and all PDS employees must submit to a screening using KARES or a combination of other state registries at the time of hire.

The KARES system conducts a fingerprint-based background check of Kentucky State Police (KSP) and Federal Bureau of Investigation (FBI) records and checks the Kentucky Nurse Aide and Home Health Abuse Registry, the Kentucky Caregiver Misconduct Registry, the Kentucky Child Abuse and Neglect (Central) Registry, Nurse Aide Abuse Registry, and the Federal List of Excluded Individuals/Entities (LEIE) list. The KARES system will also alert an employer of any new arrest findings after the date of hire listed in the KARES system. Employees listed in the KARES system must receive a yearly validation from their employer, which consists of the employer indicating within the KARES system the employee still works for them.

Traditional service agencies and PDS employers who chose not to use the KARES system must conduct screenings of the following registries:

1. Administrative Office of the Courts (AOC) Background Check operated by Kentucky Court of Justice and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment
2. Kentucky Child Abuse and Neglect (CAN) Registry operated by the Cabinet for Health and Family Services and an equivalent out-of-state agency if the individual resided or worked outside of Kentucky during the twelve (12) months prior to employment

3. Caregiver Misconduct Registry operated by the Cabinet for Health and Family Services
4. Nurse Aide Abuse Registry operated by the Kentucky Board of Nursing

For traditional service providers who conduct screenings using the AOC, CAN, and Caregiver Misconduct Registry, the agency must check, at random, twenty-five (25) percent of existing employees using the registries each year. Existing employees are those who have been employed by the agency for one (1) year or more. DMS reviews the findings of this check upon recertification of the provider and at provider billing reviews. PDS employees must undergo screenings at the time of hire and undergo recurring screenings every two years or more frequently at the PDS employer's discretion.

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

X	**No. Home and community-based services under this waiver are not provided in facilities subject to 1616(e) of the Act.**
	Yes. Home and community-based services are provided in facilities subject to 1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** *A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. Select one:*

	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
X	**Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

*Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

The DMS-approved form for hiring a legally responsible individual as a paid service provider must be submitted and approved prior to the individual providing waiver paid services.

A legally responsible individual to a minor child is defined as a parent, stepparent, an adoptive parent, or a legally appointed guardian.

A legally responsible individual to a participant age eighteen (18) or older is defined as a spouse, an appointed legal guardian, or other individual with legal authority to make decisions on behalf of a participant.

Payment for provision of participant-directed services (PDS) shall be available to an individual who is legally responsible for a minor child enrolled in a waiver program when **one** of the following extraordinary conditions exist for the participant:

1. The minor child's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating, or mobility, is directly related to his or her disability and exceeds that of his or her age matched peers; or

2. The minor child demonstrates destructive or injurious behaviors exceeding that of his or her age matched peers and such behaviors represent a risk of serious injury or death to self or others.

In addition, at least one of the following circumstances must be identified and verified to necessitate use of the legally responsible individual as a PDS employee:

1. Caregiving requirements to maintain the health and safety of the minor child in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care.
2. The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional or PDS, but is unable to secure another provider or secure sufficient provider coverage for needed services.
3. The minor child has a communication barrier exceeding that of his or her age matched peers that impacts his or her ability to effectively communicate needs and wishes to a care provider.
4. The participant has a sincerely held religious belief and cannot secure traditional providers or PDS employees who are culturally competent or share the same religion.

The approval of a legally responsible individual, or immediate family member or guardian does not guarantee payment of services and shall meet the service definition as outlined in Appendix C.

Payment for provision of participant-directed services (PDS) for adults shall be made available to any qualified person, regardless of legal responsibility or familial relationship to the participant, including a spouse, if at least one of the following circumstances has been identified and verified to necessitate use of the legally responsible individual as a PDS employee:

1. Caregiving requirements to maintain the health and safety of the participant in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care.
2. The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional and PDS, but is unable to secure another provider or secure sufficient provider coverage for all care.
3. The participant has communication barrier that impacts his or her ability to effectively communicate needs and wishes to a care provider.

4. The participant has a sincerely held religious belief and cannot secure traditional providers or PDS employees who are culturally competent or share the same religion.

The approval of a legally responsible individual, or immediate family member or guardian does not guarantee payment of services and shall meet the service definition as outlined in Appendix C.

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** *Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. Select one:*

	The State does not make payment to relatives/legal guardians for furnishing waiver services.
X	**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to** **provide services as specified in Appendix C-1/C-3.** *Specify the controls that are employed to ensure that payments are made only for services rendered.* The DMS-approved form for hiring a legally responsible individual as a paid service provider must be submitted and approved prior to the individual providing waiver paid services. A legally responsible individual to a minor child is defined as a parent, stepparent, an adoptive parent, or a legally appointed guardian. A legally responsible individual to a participant age eighteen (18) or older is defined as a spouse, an appointed legal guardian, or other individual with legal authority to make decisions on behalf of a participant. Payment for provision of participant-directed services (PDS) shall be available to an individual who is legally responsible for a minor child enrolled in a waiver program when **one** of the following extraordinary conditions exist for the participant: 3. The minor child's level of dependency in performing activities of daily living, including the need for assistance with toileting, eating, or mobility, is directly related to his or her disability and exceeds that of his or her age matched peers; or 4. The minor child demonstrates destructive or injurious behaviors exceeding that of his or her age matched peers and such behaviors represent a risk of serious injury or death to self or others. In addition, at least one of the following circumstances must be identified and verified to necessitate use of the legally responsible individual as a PDS employee: 5. Caregiving requirements to maintain the health and safety of the minor child in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the

	previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care. 6. The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional or PDS, but is unable to secure another provider or secure sufficient provider coverage for needed services. 7. The minor child has a communication barrier exceeding that of his or her age matched peers that impacts his or her ability to effectively communicate needs and wishes to a care provider. 8. The participant has a sincerely held religious belief and cannot secure traditional providers or PDS employees who are culturally competent or share the same religion. The approval of a legally responsible individual, or immediate family member or guardian does not guarantee payment of services and shall meet the service definition as outlined in Appendix C. Payment for provision of participant-directed services (PDS) for adults shall be made available to any qualified person, regardless of legal responsibility or familial relationship to the participant, including a spouse, if at least one of the following circumstances has been identified and verified to necessitate use of the legally responsible individual as a PDS employee: 5. Caregiving requirements to maintain the health and safety of the participant in the community have reduced or eliminated the ability of the legally responsible individual to maintain paid employment within the previous twelve (12) months and there is not an alternate caregiver in the home who is functionally able to provide care. 6. The legally responsible individual can demonstrate attempts within the first thirty (30) days to recruit a qualified provider, both traditional and PDS, but is unable to secure another provider or secure sufficient provider coverage for all care. 7. The participant has communication barrier that impacts his or her ability to effectively communicate needs and wishes to a care provider. 8. The participant has a sincerely held religious belief and cannot secure traditional providers or PDS employees who are culturally competent or share the same religion. The approval of a legally responsible individual, or immediate family member or guardian does not guarantee payment of services and shall meet the service definition as outlined in Appendix C.

	Other policy. *Specify:*

f. **Open Enrollment of Providers.** *Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:*

Provider enrollment is continuous and open to any willing and qualified individual or entity. The application process begins by contacting DMS Provider Enrollment through a toll-free phone number or accessing the MAP 811 provider enrollment form through the Cabinet for Health and Family Services (CHFS) website. DMS Provider Enrollment will refer any applicants who wish to serve a waiver program to the DMS Division of Community Alternatives (DCA) for certification. The provider must meet all qualifications, certification and licensing requirements set forth in Appendix C of this application for the service they seek to deliver. A potential provider must complete waiver population specific training provided by DMS during the application process and before billing for any service provided. CHFS is in the process of implementing a web-based process for enrolling providers. The full adoption date is TBD

For existing providers who add a setting, DMS or its designee staff will evaluate the setting to ensure it meets certification requirements. The provider does not need to apply for a new provider number.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

a. **Methods for Discovery:**

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*					
Sub-assurance:	*The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*					
Performance measure:	Percent of waiver providers that meet initial certification requirements prior to the furnishing of waiver services. N= Number of New Providers who meet initial certification requirements prior to furnishing services. D= Number of new contracted providers.					
Data Source: Certification survey						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*
Performance measure:	Number and percent of providers who continue to meet certification requirements following initial enrollment. N=Number of providers who continue to meet certification requirements following initial enrollment. D= Number of existing contracted providers.

Data Source: Certification survey						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*
Performance measure:	Percent of providers that meet initial OIG licensing requirement at review. N=Number of waiver providers meeting initial OIG licensing requirements. D= Number of new licensed providers.

Data Source: Reports to State Medicaid Agency on delegated administrative function						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
		State Medicaid Agency		*Weekly*	X	*100% Review*
		Operating Agency		*Monthly*		*Less than 100% Review* *Confidence interval:*

		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify:* OIG	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*
Performance measure:	Percent of providers that meet OIG licensing requirements following initial licensing. N=Number of waiver providers who continue to meet OIG licensing requirements following initial licensing. D= Number of existing licensed providers

Data Source: Reports to State Medicaid Agency on delegated administrative function						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
		State Medicaid Agency		*Weekly*	X	*100% Review*
		Operating Agency		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
		Other *Specify:OIG*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*
Performance measure:	Percent of PDS employees that meet initial personnel requirements prior to the furnishing of waiver services. N= Number of PDS employees who meet initial personnel requirements prior to furnishing services. D= Number of new PDS employees

Data Source: Provider records						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*
Performance measure:	Percent of PDS employees who continue to meet personnel requirements following initial enrollment. N=Number of PDS employees who continue to meet personnel requirements following initial enrollment. D= Number of existing PDS employees

Data Source: Provider records						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*
Sub-assurance:	*The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver*
Performance measure:	Percent of reviewed providers in which staff have successfully completed mandatory training annually. N= All reviewed providers whose staff have successfully completed mandatory training. D= Total number of reviewed providers.

Data Source: Certification surveys						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval:* 95%
		Sub-State Entity	X	*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: Delegated*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The State currently verifies that 100% of all HCB waiver providers are certified and/or licensed prior to rendering services. Providers who have completed the OIG process to receive a license are eligible to become a Medicaid provider. The States OIG monitors and re-licenses them on a three (3) year basis. If a provider's license is revoked, DMS is notified by the OIG. DMS or its designee certifies all licensed and non-licensed waiver providers. The State does not contract with non-licensed or non-certified providers. The State implements its policies and procedures and provides for training as needed related to policy changes through letters, DMS website or by attending the various associations of each of the provider entities.

b. Method for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If the Provider Agency has not provided or ensured training of their employees, DMS or its designee will follow policies and procedures as noted in the certified waiver provider regulation [Insert KAR].

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
X	*State Medicaid Agency*		*Weekly*
	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
X	*Other* *Specify:*	X	*Annually*
			Continuously and Ongoing
			Other *Specify:*

c. Timeline
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

X	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation*.

Appendix C-3: Waiver Services Specifications

Section C-3 "Service Specifications" is incorporated into Section C-1 "Waiver Services".

Appendix C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services:

X	**Not applicable**- *The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.*	
	Applicable - *The State imposes additional limits on the amount of waiver services*.	
		Limit(s) on Set(s) of Services. *There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.* *Furnish the information specified above*.
		Prospective Individual Budget Amount. *There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.* *Furnish the information specified above*.

		Budget Limits by Level of Support. *Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.* *Furnish the information specified above*.
		Other Type of Limit. *The State employs another type of limit.* *Describe the limit and furnish the information specified above*.

Appendix C-5: General Service Specifications

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Including:

1. *Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.*
2. *Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.*

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Providers are monitored for compliance with federal Final Rule as part of the certification and monitoring process. Providers are monitored every two (2) years or more frequently if necessary. As part of the certification and recertification, providers are asked specific questions regarding federal Final Rule.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title: Person-centered Service Plan (PCSP)

a. Responsibility for Service Plan Development. *Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (select each that applies):*

	Registered nurse, licensed to practice in the State
	Licensed practical or vocational nurse, acting within the scope of practice under State law
	Licensed physician (M.D. or D.O)
X	**Case Manager** *(qualifications specified in Appendix C-1/C-3)*

	Case Manager *(qualifications not specified in Appendix C-1/C-3).* *Specify qualifications:*
	Social Worker *Specify qualifications:*
	Other *Specify qualifications:*

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one***:**

	Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
X	**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. Specify:

Case management shall be conflict free. Conflict free case management requires that a provider, including any subsidiary, partnership, not-for-profit, or for-profit business entity that has a business interest in the provider, who renders case management to the participant must not also provide another waiver service to that same participant, unless the servicing provider and case manager/participant directed case manager are the only willing and qualified providers in the geographical area thirty (30) miles from the participant's residence.

Participants may request an exception to this based on lack of qualified case managers (CM) or Participant-Directed Case Managers (PDCM) in remote areas of the state. The Department for Medicaid Services (DMS) will ensure, on an individual basis, that participants who choose a case manager who could be conflicted will be free from undue influence when selecting a service provider. The CM/PDCM will need to upload a MAP-531 form requesting an exemption at the same time they upload the completed person-centered service plan (PCSP) to the DMS-approved system. The form includes the following information:

1. Documentation, including denials, showing that there are no willing providers or CM/PDCMs within thirty (30) miles of the participant's home;

2. Documentation of conflict of interest protections;

3. An explanation of how CM/PDCM functions are separated within the same entity;

4. Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within a service or case management entity.

DMS or its designee will review the request for a conflict-free exemption. Reviewers will use the DMS-approved process to verify there are no willing conflict-free service providers or willing case managers/PDCMwithin thirty (30) miles of the participant's residence.

If the exemption requested via the DMS approved form is approved or denied, the PCSP will be returned to the case manager via the DMS-approved system and the participant will be notified via a letter.

Participants are provided with a clear and accessible informal reconsideration process in cases when adverse decisions result from missing or inadequate documentation related to the initial request for exemption.

Administrative hearings will not be granted for participants who appeal a final determination where all documentation has been submitted and the ruling has been issued based on federal conflict free case management standards established in CMS 2296-F.

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. *Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.*

A person-centered service plan (PCSP) shall be an individualized plan that is led by the participant and the participant's guardian or authorized representative, if applicable, and:

a. Is collaboratively developed by:

1. A waiver participant and a waiver participant's guardian or authorized representative, if applicable;

2. The CM/PDCM;

3. The participant's person-centered team, which is comprised of representatives from each waiver provider entity who provides services for the participant; and/or

4. Any other person identified by the waiver participant or their representative**.**

b. Uses a process that:

1. Provides necessary information and support to empower the participant and the participant's guardian or authorized representative, if applicable, to direct the planning process and to have the freedom and support to control their own schedules and activities without coercion or restraint;

2. Is timely and occurs at times and locations of convenience to the participant**;**

3. Reflects cultural and educational considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and participants who have limited proficiency with the English language, consistent with 42 CFR 435.905(b)**;**

4. Offers informed choice, defined as choosing from options based on accurate and thorough knowledge and understanding, to the participant regarding the services and supports they receive and from whom**;**

5. Uses a process that provides support to the participant so the participant can lead the PCSP planning process and self-advocate for their goals, objectives, wishes, and needs to the maximum extent possible throughout the process.

c. It is the responsibility of the CM/PDCM to provide detailed information to the participant and the participant's guardian and/or authorized representative, if applicable,

regarding available waiver services and providers to meet their identified needs, driven by statewide provider information included in the DMS-maintained provider directory. CMs/PDCMs can generate local lists from the directory to provide to the participant and have use of the directory to provide options counseling on available service providers. The CM/PDCM must ensure the information from the directory is made accessible to the participant. The CM/PDCM will provide detailed information to the participant about available non-waiver services that may assist in reaching their goals and objectives.

d. All individuals participating in the development and execution of the PCSP, including participants, any authorized representatives, the CM or PDCM, and all providers responsible for implementing services, must sign the PCSP to indicate their involvement and understanding of the plan's contents. The signatures will be recorded on the DMS approved form, uploaded to, and housed in the DMS-approved system. The signatures should not be obtained until the person-centered planning process and the PCSP are complete. CM/PDCM will provide detailed information to the participant about available non-waiver services that may assist in reaching their goals and objectives. D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. *In four pages or less, describe the process that is used to develop the participant centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):*

The enrollment notice sent to the participant advises the participant and the participant's guardian and/or authorized representative, if applicable, that they must select a CM/PDCM to initiate service planning prior to receipt of services. The enrollment notice contains information on how to access information on case management agencies so that the participant may initiate contact and selection of a CM/PDCM. Once a CM/PDCM is selected, they must associate themselves in the DMS approved system.

The independent functional assessor must contact the individual to schedule the functional assessment. The assessment must be completed and uploaded in the DMS approved system.

The functional assessor is responsible to verbally advise the participant and the participant's guardian and/or authorized representative, if applicable, or informal supports who attend the assessment, of next steps to initiate services, expressly advising them of the need to schedule their person centered service planning meeting with their CM/PDCM.

After completion and upload of the functional assessment, the CM/PDCM must conduct an initial home visit.

<u>Process for Developing a Person-Centered Service Plan (PCSP)</u>

The person-centered planning process and development of the PCSP takes place as follows:

1. The first step is to clarify the needed individuals and their roles on the participant's person-centered team as defined in D-1-c. of this appendix. A participant is free to designate any family, friends, and other caregivers, both paid or unpaid, to participate in this process. The participant and the participant's guardian or authorized representative, if applicable, may remove any individuals at their discretion. The CM/PDCM must document the individuals included in the person-centered team on the DMS approved form and upload it to the DMS-approved system. The CM/PDCM must document when a support is disinvited or removed from the person-centered planning team.

For the development of the initial PCSP, the full person-centered planning team must participate. For the annual recertification of the PCSP, the participant and the participant's guardian or authorized representative, if applicable, has final authority to determine whether there is satisfactory team participation to conduct the PCSP annual review meeting. The CM/PDCM must document how information about the meeting was provided to absent members. Members of the person-centered planning team who do not attend the annual review meeting or who attend by phone must provide written documentation that they understand the contents of the PCSP and can support the participant's service needs at the requested amount, frequency, and duration.

Once the person-centered planning team is confirmed, the CM/PDCM completes the primary activities:

a. The team collectively reviews the findings of the participant's functional assessment. This process includes documenting any non-Medicaid paid or unpaid supports including information on the access and limitations of said supports, DAIL supports, and Medicaid State Plan services. For annual review meetings, the team should also review the participant's current PCSP.

b. The team works collectively under the leadership of the participant and the participant's guardian or authorized representative, if applicable, to complete an additional review of the participant's person-centered planning needs and wishes to establish goals and objectives that enhance health, safety, and welfare, community-based independence, community participation, and quality of life. Not all goals and objectives must be accomplished using 1915(c) waiver funded services.

c. The process of setting goals should include education and team support for the participant and the participant's guardian or the participant's authorized representative, if applicable. Goal and objectives must be:

- Stated Clearly: The goal or objective should be understandable to the participant and in his/her own words.
- Measurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified.
- Attainable: The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or objective should be identified and a plan put in place to help mitigate those barriers.
- Relevant: The goal or objective should be important to the participant. Steps toward the goal or objective should help the participant develop and use available resources to achieve it.
- Time-Bound: There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching

the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress.

The CM/PDCM will provide detailed information to participants about available non-waiver services that may assist in reaching their goals and objectives

d. Goals and objectives must be documented, along with an inventory of a participant's personal preferences, individualized considerations for service delivery (i.e. how to bathe, what preferred activities the participant might wish to partake in during community access, desired schedule for services, etc.), as well as information about the participant's needs, wants, and future aspirations.

The results of this conversation are to be included in the PCSP, which is housed in the DMS-approved system. It must be signed by the participant and the participant's guardian or authorized representative, if applicable. The CM/PDCM, and all other individuals responsible for the implementation of services in order to demonstrate this information was collected, shared with all person-centered team members, and is accessible to inform ongoing development and implementation of the PCSP.

2. The CM/PDCM is required to provide options counseling and education on available service options to meet a participant's person-centered goals and objectives as established in Section D-1-d., using the process for educating the participant and other team members on service providers as described in Section D-1-c.

a. Once a participant and the participant's guardian or authorized representative, if applicable, selects providers to deliver services pursuant to the frequency and amount, the CM/PDCM is expected to facilitate the referral process including, but not limited to, the obtainment of the providers' signatures on the PCSP. The providers' signatures reflect their understanding of the contents of the PCSP and consent to deliver services as indicated in the plan, in accordance with the scope, amount and frequency of service, accommodating any person-centered preferences for service delivery documented in the PCSP.

b. The CM/PDCM is responsible to ensure that the scope, frequency, amount and duration of services falls within the allowable utilization criteria and limitations set by DMS, including those documented in Appendix C and clearly document any planned changes in utilization anticipated over the course of the year (i.e. anticipated change in utilization while a participant under the age of 18 is out of school for the summer, anticipated increases due to anticipated changes in caregiver availability, etc.).

c. The CM/PDCM must maintain documentation showing that all needs identified through the functional assessment are addressed via unpaid supports or paid supports and that all paid services are appropriate in amount, duration, frequency as identified by the functional assessment.

3. Once signatures have been secured from all required person-centered team members, including the participant and the participant's guardian or authorized representative, if applicable, the CM/PDCM, and all 1915(c) waiver funded service providers delivering PCSP included services, services may be initiated. The signatures should not be obtained until the person-centered planning process and the PCSP are complete.

a. Services rendered prior to signed attestation of understanding of the contents of the PCSP by these parties will not be reimbursed.

b. The participant's signature is intended to serve only as acknowledgement and understanding of the plan's contents. Signing the PCSP does not preclude the participant from grievance or appeal.

A. Initial Development of the Person-Centered Service Plan (for a new participant's first PCSP)

Once the assessment is complete and the participant chooses a case manager, the participant and the participant's guardian and/or authorized representative, if applicable, begins the process of developing the PCSP with the case manager's assistance. Upon acceptance of a new participant, the CM/PDCM must conduct an initial home visit to begin the person centered planning process.

Person-centered service planning and development of the PCSP should follow the steps described under "*Process for Developing a Person-Centered Service Plan"* in this section.

B. Annual Recertification of the Person-Centered Service Plan

1. A participant's PCSP is recertified on an annual basis. Prior to the reviewing and modifying of the PCSP, the following activities must occur:

a. The CM/PDCM is encouraged to co-attend and must review the annual functional assessment, which is housed in the DMS-approved system. Should a CM/PDCM choose to attend the functional assessment, they are expected to support the participant in answering questions and not answer questions on his/her behalf or influence the participant's response or lack of response. The functional assessor is not to use information provided by a CM/PDCM that directly conflicts with assessment feedback provided by the participant.

The person-centered service planning can begin forty-five (45) calendar days prior to the end of the current LOC period. The PCSP must be completed and uploaded to the DMS approved system seven (7) calendar days prior to the end of the current LOC period. The LOC period is defined as the period spanning 364 calendar days from the date a participant is allocated a waiver spot in the DMS-approved system. Person-centered service planning and development of the PCSP should follow the steps described under "Process for Developing a Person-Centered Service Plan" in this section.

C. Event-Based Modification of the Person-Centered Service Plan

1. A participant and a participant's guardian or authorized representative, if applicable, may request a modification to their PCSP due to changes in their condition or service needs at any time.

a. Additionally, throughout the course of plan monitoring, the CM/PDCM is responsible to address instances when a modification to the PCSP may be appropriate. The CM/PDCM may not initiate any modification to the PCSP without the consent of the participant and the participant's guardian or authorized representative, if applicable. The services providers affected by an event-based modification to the PCSP must be involved in the process as well.

2. Certain modifications or event-based circumstances may require completion of an updated functional assessment to assess changes in the participant's needs and make necessary adjustments to the participant's PCSP. The following circumstances could merit completion of a functional assessment outside of the annual assessment cycle:

a. Inpatient admission to an institutional care setting with changes at discharge in functional ability from previous assessment including:

i. Decreased functional ability in one or more activities of daily living

ii. Decreased functional ability in three or more instrumental activities of daily living

b. A change in care setting that increases the participant's level of care, including transitions between community-based settings such as moving from a participant's own home to a residential setting.

c. Long-term change in access to or ability of an unpaid caregiver(s)

d. Observed or reported changes that result in the inability of the participant to meet goals and objectives based on the current PCSP, and/or do not provide a level of service sufficient to address health, safety**,** or welfare concerns

3. The CM/PDCM is responsible to initiate the event-based assessment in the DMS approved system.

4. The CM/PDCM will be responsible to review the updated assessment and share information about the assessment outcomes with the participant and the participant's guardian or authorized representative, if applicable. The CM/PDCM will work with the participant, and any members of the participant's person-centered team as requested by the participant, to modify the PCSP to address any requested or necessary modifications.

5. The updated PCSP must be signed by the participant and the participant's guardian or authorized representative, if applicable, the CM/PDCM, and any new service providers or providers for whom the scope, amount, or duration of service has been adjusted from what was previously consented to. The signatures should not be obtained until the person-centered planning process and the PCSP are complete. The modified PCSP will remain in effect until the end of the participant's original LOC year. The event-based functional assessment does not eliminate the need for a participant's annual PCSP recertification. All providers delivering services will be notified via the DMS-approved system when a participant's PCSP has changed and will be responsible to review changes and work with the participant's CM/PDCM and person-centered team to make any adjustments or deploy mitigation strategies to assure continuity of care.

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** *Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.*

Participant needs are identified through the functional assessment and via person-centered planning meetings. If assessed needs cannot be met using 1915(c) and other community-based paid or unpaid services, if the participant chooses not to access services or address certain community-based needs, or environmental, health, safety or welfare risks are identified by any member of the person-centered planning team, risk mitigation efforts must occur and be documented by the participant's case manager. Risks must be documented in the DMS approved system The CM/PDCM will assess the participant's individual risks by reviewing the participant's functional assessment, any critical incident reports, the participant's behavior

support plan (if applicable), and through discussion with the person-centered planning team. When applicable, the following should be documented in the DMS approved system: :

1. Medical diagnoses that may require emergency intervention

2. Behaviors that could harm the participant's health, safety, and welfare or harm the health, safety, and welfare of others

3. Emergency backups for paid caregivers who do not show up

4. Any other identified or observable risks that could adversely affect the environment, health, safety, and welfare of the participant or pose a risk of harm to service providers

5. Any identified risks related to the ability of a Participant-Directed Services (PDS) employee hired by the participant to fulfill his or her responsibilities as identified in the participant's person-centered plan and/or preserve the participant's health, safety and welfare

Participants with legal decision-making authority have the right to accept risks. The participant's CM/PDCM is responsible to discuss risks with the participant and the participant's guardian or authorized representative, if applicable, and make sufficient efforts to engage the participant and the participant's person-centered team to develop risk mitigation strategies that reduce risks, particularly those adversely impacting health, safety**,** or welfare of the participant, individuals with whom the participant resides, and those who interact with the participant in order to deliver the PCSP.

A participant's CM/PDCM must document the outcomes of risk mitigation strategies. Documentation must demonstrate due diligence in addressing risks with the participant and members of the person-centered team. If a participant refuses to engage in risk mitigation strategies and accepts risks, the CM/PDCM is responsible to assess the participant's understanding of risks and potential consequences. The CM/PDCM is responsible to educate the participant when risks impede the ability of providers to safely and effectively deliver services, which is a violation of a participant's signed rights and responsibilities form and must make participants aware of disruption or loss of service due to ongoing risks that are not mitigated. The CM/PDCM must proceed in this manner with any participants with an appointed guardian with decision-making authority.

If concern exists that a participant may not demonstrate understanding of risk and consequence, the CM/PDCM is expected to refer participants to child or adult protective services to address any possible self-neglect, caregiver neglect, or other abuse/neglect/exploitation issues that may exist. The CM/PDCM and all Medicaid funded providers are required to cooperate with protective service investigations. Findings of an investigation may prompt necessary adjustment to the PCSP, in which case the CM/PDCM should proceed with adjustment to the PCSP in accordance with the process outlined to make an event-based modification to the PCSP as established Section D-1.c.D.1-5.

Additional risk mitigation occurs in response to critical incident investigation and remediation, as described in Appendix G.

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** *Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.*

The participant's CM/PDCM is required to provide information about available services including, but not limited to:

- Medicaid state plan funded services, non-Medicaid paid or unpaid supports, and DAIL supports that may support the participant's home and community-based needs
- Traditional, Participant-Directed Service (PDS), and blended options
- Services available on their 1915(c) waiver and how they can assist the participant to advance goals as specified in the PCSP
- Available service providers in the area

Understanding of freedom of choice

The CM/PDCM is responsible for assisting the participant and the participant's guardian or authorized representative, if applicable, in choosing his or her providers of services specified in the PCSP. This assistance may include telephonic or on-site visits with participants and their families, assisting them in accessing the provider listing, answering questions about providers, and informing them or demonstrating use of the Partner Portal system and information housed within. CMs/PDCMs are trained by DMS to respond to participant inquiries regarding choice of provider in a manner that avoids conflict of interest and/or conveys personal, subjective opinion. The CM/PDCM will ensure**,** on an individual basis**,** that participants who have a conflicted case manager due to their geographic location, and have been approved to do so by DMS, will be free from undue influence regarding choice of providers and will document those efforts in case records housed in the DMS-approved system.

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** *Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):*

Upon completion of the PCSP, it is the responsibility of the CM/PDCM to submit the PCSP through the DMS-approved system for review and service authorization. A service authorization shall not be issued without appropriate review and approval.

Once the complete PCSP is submitted, it will undergo system checks and, if indicated, it will be reviewed by DMS. If the PCSP is approved, the participant will receive a letter in the mail. A copy of the notification is also available in the DMS approved system. If the determination results in an adverse decision, the participant will receive an adverse decision notice, which informs of what was denied, why it was denied, and their right to an informal reconsideration and a fair hearing, via certified mail. The CM/PDCM is responsible for notifying providers of approval or denial of the completed PCSP.

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. *The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan*:

	Every three months or more frequently when necessary
	Every six months or more frequently when necessary.
X	**Every twelve months or more frequently when necessary**
	Other schedule ***Specify the other schedule:***

i. Maintenance of Service Plan Forms. *Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (check each that applies):*

X	**Medicaid agency**
	Operating agency
X	**Case manager**
X	**Other** ***Specify:*** Copies of the PCSP are retained in DMS approved system until after the participant's termination and then maintained electronically for five (5) years.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. *Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.*

The participant's CM/PDCM is responsible for the coordination and monitoring of all the participant's waiver services included in the PCSP and will assist in identifying and connecting the participant with non-waiver services. The CM/PDCM shall conduct face-to- face visits with the participant monthly, with at least one visit at the participant's current place of residence every three months. The visit must include input from the participant and the participant's guardian, authorized representative, or PDS representative, if applicable. For participants with communication barriers, the CM/PDCM must take steps to ensure the conversation is conducted in a way that is accessible to the participant. This could include arranging for an interpreter or a communication device.

The face-to-face contact must include discussions about:

- Progress toward PCSP goals, including any changes in goals or objectives
- Satisfaction with services delivered via the PCSP
- Confirming any new needs and addressing whether PCSP modification may be necessary
- Review of utilization and cost of utilization
- Any concerns with health, safety, and welfare, and/or risk mitigation needs
- Review of access to any additional community-based supports, including non-Medicaid funded services, to address where additional assistance or linkage may be needed

The CM/PDCM is also responsible to use continued professional judgment in screening for evidence of possible abuse, neglect**,** or exploitation, and/or the possibility of an unreported critical incident. The participant's CM/PDCM must report all suspected critical incidents, including abuse, neglect**,** and exploitation concerns as defined in Appendix G.

All contact and monitoring activities, observations, and outcomes must be documented via monthly case notes housed in the DMS-approved system.

b. **Monitoring Safeguards.** *Select one:*

	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
X	**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

Providers for the participant, or those who have an interest in or are employed by a provider for the participant, must not provide case management or develop the PCSP. For participants who request an exception to this, DMS will require the CM/PDCM to provide the following to ensure the participant is free from undue influence:

1. Documentation showing that there are no willing service providers and CM/PDCMs within thirty (30) miles of the participant's home

2. Documentation of conflict of interest protections

3. An explanation of how CM/PDCM functions are separated within the same entity

4. Demonstration of the availability of a clear and accessible dispute resolution process that advocates for participants within service or case management entity

Exemptions for conflict free case management shall be requested initially and, upon reassessment or at least annually.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

a. **Methods for Discovery:**

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*					
Sub-assurance:	*Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*					
Performance measure:	Percent of service plans with documented risk mitigation information. N=number of service plans with a risk assessment that also have documented risk mitigation information. D=Number of service plans reviewed.					
Data Source: Service plan documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
		Other *Specify:*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other	X	*Annually*

		Specify:		
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*					
Sub-assurance:	*Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*					
Performance measure:	Percent of participants surveyed who said that their case manager gets them what they need as indicated.. N= All respondents who said that there case manager gets them what they need per survey data.. D= All participants who responded to that question.					
Data Source: Participant survey data						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval:* 95%
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):			**Frequency of data aggregation and analysis (check each that applies):**		
	X	*State Medicaid Agency*			*Weekly*	

		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*
Sub-assurance:	*Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*
Performance measure:	Percent of waiver participants whose service plans were updated and submitted prior to the annual recertification date. N= Number of waiver participants whose service plans were updated and submitted prior to the annual recertification date. D= Number of participants whose service plans were updated and submitted.

Data Source: Service plan documentation

Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
	Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
			Continuously and Ongoing		*Other* *Specify:*
			Other *Specify:*		

Data Aggregation and Analysis

	Responsible Party for data aggregation and analysis (check each that applies):		Frequency of data aggregation and analysis (check each that applies):	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other Specify:

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*
Sub-assurance:	*Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*
Performance measure:	The percent of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person-centered plan. N=the number of records reviewed that demonstrate that the correct type, amount, scope and frequency of services were provided according to the person-centered plan. D=Number of records reviewed.

Data Source: Service plan documentation

	Responsible Party for data collection/generation (check each that applies):		Frequency of data collection/generation (check each that applies):		Sampling Approach (check each that applies	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval:* 95%
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*

				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):			**Frequency of data aggregation and analysis (check each that applies):**		
	X	*State Medicaid Agency*			*Weekly*	
		Operating Agency			*Monthly*	
		Sub-State Entity		X	*Quarterly*	
		Other *Specify:*		X	*Annually*	
					Continuously and Ongoing	
					Other *Specify:*	

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*					
Sub-assurance:	*Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*					
Performance measure:	Percent of participants who received participant directed services within the approved service limit. N= Number of participants who received participant directed services within the approved service limit. D= Number of participants who received participant directed services.					
Data Source: Service plan documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*

				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*
Sub-assurance:	*Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*
Performance measure:	Percent of waiver participant records with an appropriately completed and signed freedom of choice form specifying choice was offered between waiver services and institutional care, waiver services and waiver providers. N= Number of participant records with an appropriately completed and signed freedom of choice form. D= Number of participant records.

Data Source: Service plan documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other*	X	*Annually*		*Stratified.*

		Specify: Delegated Entity				*Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):			**Frequency of data aggregation and analysis (check each that applies):**		
	X	*State Medicaid Agency*			*Weekly*	
		Operating Agency			*Monthly*	
		Sub-State Entity		X	*Quarterly*	
		Other *Specify:*		X	*Annually*	
					Continuously and Ongoing	
					Other *Specify:*	

Methods for Discovery:	*The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*
Sub-assurance:	*Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.*
Performance measure:	Percent of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. N= Number of waiver participants whose records contain confirmation of notification of the option to choose consumer directed options. D= Number of waiver participants.

Data Source: Service plan documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other*	X	*Annually*		*Stratified.*

		Specify: Delegated Entity				*Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

DMS or its designee will review critical incidents and waiver service and state plan utilization for appropriate response to need. DMS will track, trend, and review grievances and complaints for system wide issues.

b. Method for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

If DMS or its designee determines an identified need noted on the assessment has not been addressed on the PCSP, DMS or its designee will issue written notification to the provider requiring additional information as to how these needs will be addressed.
Identified individual problems are researched and addressed by DMS or its designee. If issues are noted, DMS will follow the policies and procedures as noted in (Insert Certified Waiver KAR).

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):	**Frequency of data aggregation and analysis (check each that applies):**

X	State Medicaid Agency		Weekly
	Operating Agency		Monthly
	Sub-State Entity	X	Quarterly
	Other Specify:	X	Annually
			Continuously and Ongoing
			Other Specify:

c. Timeline
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

X	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation*.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

X	***Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.***
	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

	Yes. The State requests that this waiver be considered for Independence Plus designation.
X	***No. Independence Plus designation is not requested.***

Appendix E: Participant Direction of Services E-1: Overview (1 of 13)

a. Description of Participant Direction. *In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.*

Each waiver participant chooses between three service delivery options: traditional, participant-directed services (PDS), or a combination of the two known as blended services. If interested in the PDS or blended option, the participant completes a PDS self-assessment tool. The tool identifies the PDS tasks a participant can perform independently and the PDS tasks that will require support from others. During person-centered planning meetings, the participant works with the Participant-Directed Case Manager (PDCM) to identify the services he/she wants to self-direct. Participants who choose the PDS option are supported by their PDCM who takes on the following tasks:

a. Educating the participant and the participant's guardian and/or authorized representative, if applicable, on the rights, responsibilities and risks of the PDS option

b. Assisting with the development of the person-centered service plan (PCSP)

c. Assisting with the hiring and managing of employees

d. Monitoring the participant's health, safety, and welfare and ensuring that services are delivered effectively and meet the participant's needs through monthly, face-to-face visits.

The PDCM agency is responsible to help the participant with employee payroll and other financial activities related to the participant's employees. The participant can also choose a PDS representative to assist him/her with self-directing services. This individual helps the participant in fulfilling his/her duties as a PDS employer using person-centered principles.

A review and renewal of the PCSP, including service delivery options, with the participant and the participant's guardian and/or authorized representative takes place at least annually and can be modified more frequently as needs change.

Appendix E: Participant Direction of Services E-1: Overview (2 of 13)

b. Participant Direction Opportunities. *Specify the participant direction opportunities that are available in the waiver. Select one:*

X	**Participant: Employer Authority**. *As specified in Appendix E-2, Item a, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority*.
	Participant: Budget Authority. *As specified in Appendix E-2, Item b, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.*

	Both Authorities. *The waiver provides for both participant direction opportunities as specified in Appendix E-2. Supports and protections are available for participants who exercise these authorities.*

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

x	**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor
	The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services E-1: Overview (3 of 13)

d. Election of Participant Direction. *Election of participant direction is subject to the following policy (select one):*

	Waiver is designed to support only individuals who want to direct their services.
X	**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria:

Appendix E: Participant Direction of Services E-1: Overview (4 of 13)

e. Information Furnished to Participant. *Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.*

Each participant is afforded the choice of traditional, PDS, or blended services. At the time of the initial person-centered planning meeting, during the annual recertification of the PCSP, and as needed, the PDCM is required to provide the following to the participant's guardian or authorized representative:

- Information about PDS, traditional, and blended service options
- Appropriate services based on assessed needs, and
- Selection of providers

Participants are fully informed of the rights, responsibilities, and risks of all service delivery options, including serving as an employer in the PDS option and the supports offered by the PDCM to assist participants in executing their responsibilities as an employer. Participants and the participant's guardian or authorized representative, if applicable, should also be informed of the potential liabilities associated with participant direction, including the cost of pre-employment screenings for employees, fraud, and abuse. The PDCM must provide the information to participants in a format that is most appropriate and understandable for them, taking into account reading level and preferred method of communication. The PDCM must provide information in writing and verbally to the participant. After the initial person-centered planning meeting, the PDCM sets up the next person-centered planning meeting, where all individuals required for implementation of services, along with the participant and the participant's guardian or authorized representative, if applicable, are present and must sign the completed PCSP. Person-centered planning meetings are conducted at least annually and at any point of inquiry by the participant or participant's guardian/authorized representative, if applicable.

Participants and the participant's guardian or authorized representative, if applicable, are required to document their understanding of service delivery options. The PDCM also verifies this understanding using the DMS-approved process, recording this information in the participant's PDS self-assessment tool. The PDS self-assessment tool is used to:

a. Educate participants on employer authorities
b. Facilitate review of participant's role and responsibilities, including a task specific breakdown, to effectively self-direct waiver services
c. Allow participants to identify where they will need assistance with roles and responsibilities, and select their preferred source of assistance
d. Identify participant's needs to enhance or keep the participant independent

The PDS self-assessment tool is completed by the PDCM, participant, and the participant's guardian and/or authorized representative. The tool allows the participant to identify, at a task-specific level, which tasks he or she can conduct independently and which tasks might or will require assistance from a designated representative, informal support, or the PDCM. The PDCM uses this tool upon initiation of PDS and annually to guide oversight and support activities and to discern the level of assistance that will need to be formally provided on a regular basis by the PDCM. The results of the PDS self-assessment tool are housed in the Department for Medicaid Services' (DMS) approved system.

Appendix E: Participant Direction of Services E-1: Overview (5 of 13)

f. Participant Direction by a Representative. *Specify the State's policy concerning the direction of waiver services by a representative (select one):*

	The State does not provide for the direction of waiver services by a representative.

X	**The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (check each that applies):

X	**Waiver services may be directed by a legal representative of the participant.**
X	**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** *Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant*:
	An adult waiver participant may freely choose a PDS representative to assist in directing waiver services as the participant needs. However, the PDS representative may not be hired as an employee to provide any of the participant's self-directed waiver services. The PDS representative must adhere to person-centered principles and fulfill the responsibilities as a PDS employer, demonstrating commitment to the goals and objectives established in the participant's PCSP and PDS self-assessment tool. The PDS representative must complete training on fraud, abuse, neglect, and exploitation. The PDS representative must also sign the rights, risks, and responsibilities form annually. This form explains the rights and responsibilities of the waiver program and the consequences, which may include termination from the program, if they are not followed. The PDCM is responsible for monitoring the participant's PCSP and ensuring that needed services are being appropriately provided to the participant. If the PDCM has concerns that the PDS representative is not operating in the best interest of the participant, the PDCM shall work with the participant and PDS representative to establish a corrective action plan (CAP) for the PDS representative. If the issues continue, PDS service delivery will be terminated following the appropriate process described in section E-1-l and m of this application Upon termination from the PDS program, the participant and the participant's guardian or authorized representative, if applicable, are provided with written information regarding the traditional program and available providers. The PDCM shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a CAP, the outcomes, and the support provided in obtaining traditional services. A participant-directed service shall not be terminated until a traditional service provider is ready to provide services. If it is suspected that the participant's health, safety, and welfare is at risk, the PDCM immediately begins the process of determining steps and developing a CAP up to and including involuntary termination for PDS. The PDCM must also report any critical incidents, as defined in Appendix G.

Appendix E: Participant Direction of Services E-1: Overview (6 of 13)

g. Participant-Directed Services. *Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.*

Waiver Service	***Employer Authority***	***Budget Authority***
Adult Day Health		
Case Management		

Participant Directed Case Management		
Personal Assistance		
Home and Community Supports	**x**	
Environmental and Home Modifications		
Goods and Services		
Home Delivered Meals		
Non-specialized Respite	x	
Specialized Respite		

Appendix E: Participant Direction of Services E-1: Overview (7 of 13)

h. Financial Management Services. *Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. Select one*:

X	**Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).** *Specify whether governmental and/or private entities furnish these services. Check each that applies*:	
	X	*Governmental entities*
		Private entities
	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.	

Appendix E: Participant Direction of Services E-1: Overview (8 of 13)

i. Provision of Financial Management Services. *Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. Select one*:

X	**FMS are covered as the waiver service specified in Appendix C-1/C-3** **The waiver service entitled**: Participant directed services
	FMS are provided as an administrative activity.

Provide the following information

i. **Types of Entities:** *Specify the types of entities that furnish FMS and the method of procuring these services*:

Area Agencies on Aging and Community Mental Health Centers (Quasi-governmental entities) may furnish this service. ii. **Payment for FMS**. *Specify how FMS entities are compensated for the administrative activities that they perform*:

DMS compensates PDCM agency providers based on a specified rate per month per participant.

iii. **Scope of FMS**. *Specify the scope of the supports that FMS entities provide (check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

X	**Assist participant in verifying support worker citizenship status**
X	**Collect and process timesheets of support workers**
X	**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
X	**Other** *Specify:* • Facilitate self-assessment of participant's support needs related to employer authority; • Arrange or provide necessary support to participants as identified in the self-assessment, to offer needed assistance to execute employer authority; • Monitor the participant's execution of budget and/or employer authority and document any identified risks, challenges, and outcomes; • The development and/or review of the PCSP, including monitoring of the effectiveness of the PCSP to advance person-centered goals and objectives and respond to changes in participant goals and objectives; • Support selection and provide on-going coordination between the participant and the chosen participant directed case management agency; and, • Monitoring of corrective action plans (CAP) for PDS employees.

Supports furnished when the participant exercises budget authority:

	Maintain a separate account for each participant's participant-directed budget
	Track and report participant funds, disbursements and the balance of participant funds
	Process and pay invoices for goods and services approved in the service plan
	Provide participant with periodic reports of expenditures and the status of the participant-directed budget

	Other services and supports *Specify:*

Additional functions/activities:

	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
X	***Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency***
X	***Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget***
	Other *Specify:*

iv. **Oversight of FMS Entities**. *Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.*

All Financial Management Services are subject to annual reviews by DMS or its designee. This review shall include audits of submitted timesheets, reports of service utilization provided to PDCM or participant and participant's guardian or authorized representative, if applicable, and any other supporting documentation regarding payments issued by the PDCM Agency as part of Financial Management Service. The audit shall identify any deficiencies and appropriate actions, including CAPs or penalties, to be taken by DMS or its designee to ensure compliance and appropriate payments.

Appendix E: Participant Direction of Services E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. *In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (check each that applies):*

	Case Management Activity. *Information and assistance in support of participant direction are furnished as an element of Medicaid case management services*. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver*:

X	**Waiver Service Coverage**. *Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):*	
	Participant Directed Wavier Service	**Information and Assistance Provided through this Waiver Service Coverage**
	Case Management	X
	Participant Directed Case Management	X
	Administrative Activity. *Information and assistance in support of participant direction are furnished as an administrative activity.* *Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*	

Appendix E: Participant Direction of Services E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

X	**No. Arrangements have not been made for independent advocacy.**
	Yes. Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

Appendix E: Participant Direction of Services E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. *Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:*

A participant may voluntarily dis-enroll from PDS at any time.

The PDCM must meet with the participant to provide support and information on the impact of dis-enrolling from PDS and to offer any support that may be required to mitigate issues prompting the participant to request dis-enrollment.

The PDCM is responsible for informing the participant of the impacts and risks of disenrollment. If the participant still wishes to continue with disenrollment the PDCM will assist the participant, their guardian or authorized representative, if applicable, in locating traditional service providers to meet their needs. The PDCM shall take action in locating traditional service providers within seven (7) calendar days of the participant's, their guardian or authorized representative, request to disenroll.

.

If the participant selects to terminate PDS, they may be subject to waiver program termination based on the following guidelines:

- If a participant does not access any waiver services, outlined in the PCSP, for a period greater than sixty (60) consecutive calendar days without receiving an extension based on demonstration of good cause, the participant may be terminated from the waiver.
- A one-time, sixty (60) consecutive calendar days extension may be granted in the event of good cause.
- Good cause is defined as circumstances beyond the control of the participant that affects the participant's ability to access funding or services, which includes:
    - Illness or hospitalization of the participant that is not expected to last beyond the good cause extension; or
    - The participant and participant's guardian or authorized representative, if applicable, made diligent contact with a potential provider to secure placement or access services but has not been accepted within the sixty (60) consecutive calendar day's time period.

Appendix E: Participant Direction of Services E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. *Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.*

The PDCM is responsible for monitoring the participant's PCSP and ensuring needed services are provided effectively to the participant to advance his or her goals and objectives, as identified in the PCSP. If services are not being provided as documented within the PCSP or if the PDCM has concerns that the participant's needs are not met, the PDCM shall work with the participant and the participant's guardian or authorized representative, if applicable, to create a service improvement plan (SIP) with the participant within fourteen (14) calendar days of identifying the service delivery issue. A SIP is developed to address issues that interfere with the delivery of PDS services, including but not limited to:

1. The participant does not comply with the PCSP, including over-utilization of services, or accessing unauthorized waiver services not included in the PCSP;

2. The participant and/or a family member, an employee, guardian or authorized representative consistently refuses services from a provider;

3. The participant and/or a family member, an employee, guardian or authorized representative threatens, demonstrates abusive behavior towards a provider;

4. Imminent threat of harm to the participant's health, safety, or welfare is observed; or

5. The participant a family member, an employee, guardian or authorized representative interferes with the delivery of case management activities, as defined in Appendix C-1.

Immediate action may need to be taken in cases where health, safety, or welfare impacts are imminent.

The PDCM monitors the progress of the SIP and resulting outcomes. A SIP must be conducted over a minimum of thirty (30) calendar days to adequately address issues. If the participant is unable to resolve the issue or unable to develop and effectively implement the intended improvements stipulated in a SIP within ninety (90) calendar days of identification of the issue, the PDCM will issue a findings packet to DMS to determine if the participant should be terminated from PDS. PDS service delivery will be terminated through the appropriate process as follows:

1. The participant receives a letter notifying them of termination from the PDS option. The letter includes appeal rights as defined in Appendix F.

2. The participant and the participant's guardian or authorized representative, if applicable, are provided with information, regarding the traditional program and available providers, in a manner that is understandable to the participant. The PDCM assists the participant/authorized representative with identifying a traditional service provider they would like.

3. The PDCM coordinates with traditional providers to make sure that there are no lapses in service and that updates to the PCSP are made in a timely manner. The PDCM shall document the reason for the PDS option withdrawal, actions taken to assist the participant to develop a SIP and the outcomes, and the support provided in obtaining traditional services.

4. The participant is provided written notice of the option for an administrative hearing thirty (30) calendar days prior to the transition to traditional services.

5. If the participant cannot obtain a willing traditional provider within sixty (60) calendar days from the termination notice, he/she is discharged from waiver with DMS approval. A one-time, sixty (60) calendar days extension may be granted in the event of good cause, as defined in E-1-l.

6. Additional and immediate action may be taken if the participant's health, safety, or welfare is at risk. The PDCM assists the participant in understanding the risks and consequences and may immediately assist the participant in transferring to a traditional waiver provider of the participant's choice. The PDCM notifies DMS of the transfer and notify other appropriate agencies and authorities of suspected abuse, safety, and neglect allegations through the proper channels and critical incident reports as described in Appendix G of this waiver application.

7. If substantiated by the Office of the Inspector General (OIG), cases of fraud may result in the participant's termination from PDS, the waiver, or Medicaid.

Appendix E: Participant Direction of Services E-1: Overview (13 of 13)

n. Goals for Participant Direction. *In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services*.

Table E-1-n

	Employer Authority Only	***Budget Authority Only or Budget Authority in Combination with Employer Authority***
Waiver Year	***Number of Participants***	***Number of Participants***
Year 1	2600	
Year 2	2650	
Year 3	2700	
Year 4	2750	
Year 5	2800	

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status**. *Specify the participant's employer status under the waiver. Select one or both:*

	Participant/Co-Employer. *The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant- selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.* *Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff*:
X	**Participant/Common Law Employer.** *The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions*.

ii. **Participant Decision Making Authority**. *The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Select one or more decision making authorities that participants exercise*:

X	*Recruit staff*
	Refer staff to agency for hiring (co-employer)
	Select staff from worker registry

X	*Hire staff common law employer*
X	*Verify staff qualifications*
X	*Obtain criminal history and/or background investigation of staff* *Specify how the costs of such investigations are compensated:*
	The participant, as the employer, is responsible to ensure the potential hire meets qualifications. The cost of obtaining criminal background checks, drug testing and all costs associated with training may be covered by the employee, employer or other interested third parties, such as family members, friends, churches, local community organizations, etc.
X	*Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.*
X	*Determine staff duties consistent with the service specifications in Appendix C-1/C-3.*
X	*Determine staff wages and benefits subject to State limits*
X	*Schedule staff*
X	*Orient and instruct staff in duties*
X	*Supervise staff*
X	*Evaluate staff performance*
X	*Verify time worked by staff and approve time sheets*
X	*Discharge staff (common law employer)*
	Discharge staff from providing services (co-employer)
	Other *Specify:*

E-2: Opportunities for Participant-Direction (2 of 6)

b. **Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. **When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. Select one or more:**

	Reallocate funds among services included in the budget
	Determine the amount paid for services within the State's established limits

	Substitute service providers
	Schedule the provision of services
	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
	Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
	Identify service providers and refer for provider enrollment
	Authorize payment for waiver goods and services
	Review and approve provider invoices for services rendered
	Other *Specify:*

E-2: Opportunities for Participant-Direction (3 of 6)

b. **Participant - Budget Authority**

ii. Participant-Directed Budget *Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available*.

The waiver does not offer budget authority. This section is not applicable.

E-2: Opportunities for Participant-Direction (4 of 6)

b. **Participant - Budget Authority**

iii. Informing Participant of Budget Amount. *Describe how the State informs each participant of the amount of the participant- directed budget and the procedures by which the participant may request an adjustment in the budget amount.*

The waiver does not offer budget authority. This section is not applicable.

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

	Modifications to the participant directed budget must be preceded by a change in the service plan.
	The participant has the authority to modify the services included in the participant directed budget without prior approval.

	Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

E-2: Opportunities for Participant-Direction (6 of 6)

b. **Participant - Budget Authority**

v. Expenditure Safeguards. *Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards*:

The waiver does not offer budget authority. This section is not applicable.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing.

Procedures for Offering Opportunity to Request a Fair Hearing. *Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.*

Participants are first informed of their right to an administrative hearing, the reconsideration, and the grievance processes during the initial face-to-face visit through distribution of the waiver welcome packet. Verification that the participant has been informed of their rights to an administrative hearing is obtained by signature of the participant on the DMS approved form. A participant may request assistance from their CM/PDCM to submit a request for an administrative hearing. If the participant does not have a CM/PDCM, or would prefer assistance from another party, the following entities may assist participants with filing an administrative hearing request:

1. Office of the Ombudsman
2. Kentucky Protection and Advocacy
3. Office of Legal Support
4. By calling the Medicaid Waiver Help Desk

Materials provided to the participant include the participant's rights and process to request an administrative hearing in the event of one of the following adverse actions:

a. not providing a participant the choice of home and community based services as an alternative to institutional care
b. denying a participant the service(s) of their choice, service delivery option of their choice, or the provider(s) of their choice
c. actions to deny, suspend, reduce, or terminate services.

All administrative hearings are handled by the Hearing and Appeals Branch of the Cabinet for Health and Family Services (CHFS).

Participants who are denied level of care, suspension, reduction, or termination of services, or participant-directed services (PDS) employee exemptions are issued written notification of appeal rights at the time of adverse action. These rights are contained as a part of the adverse action notices issued by DMS or its designee. When this function is conducted by a designee, DMS or its designee will develop all templates and perform oversight activities to ensure timeliness and that the adverse action notice includes the following:

- Appropriate denial or change information;
- Administrative hearing rights;
- Instructions for reconsideration or administrative hearing; and
- Contact information to request assistance with a request for appeal.

All administrative hearing rights are outlined in 907 KAR 1:563 which requires written notification of appeal rights to the participant and stipulates that participants must request, in writing, an administrative hearing within thirty (30) calendar days of the date of the notification. Services will continue as previously indicated in the person-centered service plan (PCSP) prior to the adverse action if the request for an administrative hearing is made within ten (10) calendar days. The notices are generated electronically at the time of an adverse action, delivered, via certified mail, to the participant and the participant's guardian or authorized representative, if applicable, delivered electronically to the CM/PDCM, and recorded electronically in the DMS-approved system.

Appendix F-2: Additional Dispute Resolution Process

a. ***Availability of Additional Dispute Resolution Process.*** *Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. Select one*:

	No. This Appendix does not apply
X	**Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** *Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.*

A reconsideration is an optional process that provides the participant an opportunity to resolve the adverse action outside of the administrative hearing process while still retaining the option to pursue an administrative hearing in the future. The reconsideration is also the most efficient and quickest way to resolve an adverse action.

The participant may request an administrative hearing immediately following an adverse action notice or after they have pursued the reconsideration process. Furthermore, the reconsideration process is not a pre-request for an administrative hearing. Participants are first informed of the reconsideration process during the initial functional assessment, at the same time they are informed of the administrative hearing, and complaint and grievance process. Additionally, participants are informed of those processes annually upon re-assessment and in any adverse action notice.

DMS provides for a reconsideration process. This process is operated by DMS or its designee. This reconsideration process is summarized in the following steps:

1. The provider, participant, or the participant's guardian/authorized representative acting on the participant's behalf can request a reconsideration.

- A reconsideration request must be made in writing and can be submitted to DMS via U.S. Mail or by email. Participants with a disability that prevents them from submitting a request in writing can call the DMS Division of Community Alternatives for assistance.
- Reconsideration requests must be postmarked within fourteen (14) calendar days from the date of the written notice of adverse action.
- Reconsideration requests postmarked or dated and timestamped more than fourteen (14) calendar days from the date of the written notice of adverse action are considered invalid. The individual making the request will receive an out of timeframe letter notifying them that the request was not made in the proper timeframe.

If a reconsideration request is made after the fourteen (14) calendar day timeframe ends, the provider, participant, or the participant's guardian/authorized representative acting on the participant's behalf can still request an administrative hearing.

- The out of timeframe letter will explain the right to an administrative hearing and the process for requesting one as described in Appendix F-1.
- A request for an administrative hearing must be made in writing and postmarked within thirty (30) calendar days of the initial written notice of adverse action. Requests for an administrative hearing cannot be made via email.

1. DMS or its designee will conduct the reconsideration, render a determination, and send a letter to the provider, participant and participant's guardian or authorized representative, if applicable, within the timeframe set forth in [insert KAR]. If the adverse action is upheld, the letter will be sent via certified mail. If the adverse action is overturned, the letter will be postmarked within the timeframe referenced in [insert KAR].
2. An adverse action may be overturned, upheld, or modified as a result of a reconsideration.
    a. If the reconsideration determination upholds or modifies the original decision resulting in an adverse action, the participant, the participant's guardian or the participant's authorized representative may request an administrative hearing. Information on how to request an administrative hearing is included in the reconsideration determination letter. The participant has thirty (30) calendar days from the reconsideration determination to request an administrative hearing. The request must be received or postmarked within thirty (30) calendar days of the reconsideration determination letter. If the request is received or postmarked within ten (10) calendar days, previously approved services of the reconsideration determination letter, services will continue until receipt of the final order. Administrative Hearings are handled by the Hearing and Appeals Branch of CHFS as described in section F-1.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select One*:

	No. This Appendix does not apply
X	**Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. *Specify the State agency that is responsible for the operation of the grievance/complaint system*:

Participants have the opportunity to register grievances and complaints concerning the provision of services by waiver providers.

The grievances and complaints system shall be operated by the Department for Medicaid Services (DMS).

Filing a grievance or complaint is not a pre-requisite or substitution for a reconsideration or administrative hearing.

c. Description of System. *Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Waiver participants may register any grievance or complaint regarding waiver service provision or service providers by contacting DMS via Medicaid Waiver Help Desk, via email, or via mail. A complaint or grievance can be submitted at any time. These complaints and grievances are documented in a central database administered by DMS. All complaints and grievances are tracked and trended by DMS to identify if additional provider trainings and participant education opportunities should be developed and conducted.

A complaint is an expression of dissatisfaction from the participant regarding some aspect of their 1915(c) waiver service delivery or experience that does not require follow up as determined by the categorization process described below.

A grievance is an expression of dissatisfaction from the participant due, in part or in full, to the failure of DMS, or a provider to adhere to established operating procedures, regulations, and waiver requirements. Grievances may require DMS follow up and resolution as determined by the categorization process described below.

Upon receiving a complaint or grievance, DMS will immediately assess and categorize the gravity of the grievance or complaint and determine if an immediate response, timely response or acknowledgement of the grievance or complaint is required.

1. An immediate response is necessary if a participant's health, safety, or welfare are jeopardized. Grievances will be addressed and the appropriate parties notified immediately of learning of the event. DMS will contact the participant via his/her preferred method of communication once the grievance is resolved and throughout the investigation as necessary.
2. DMS will provide a timely response if a grievance requires action to be taken but does not put the health, safety, or welfare of the participant in jeopardy. These responses will be addressed as soon as possible. Some action, including opening an investigation and notifying the appropriate parties, must be taken within seven (7) calendar days of receiving the grievance. Resolution of the grievance is dependent on the nature of the grievance and resolution is not required to occur within seven (7) calendar days. DMS will contact the participant via his/her preferred method of communication once the grievance is resolved.
3. If no action is necessary, DMS will document the complaint within the DMS-approved system.

During this complaint/grievance assessment, DMS will determine if other agencies are responsible for licensure, certification, or monitoring of the provider and will notify or involve these agencies as appropriate. DMS will also determine if the grievance/complaint meets the definition of a critical incident as specified in Appendix G. If a critical incident has occurred, DMS will alert the appropriate parties and follow the process described in Appendix G of this waiver application.

Lastly, DMS will require all waiver service providers to implement policies and procedures to address participant complaints and grievances independently from the state complaint/grievance process. The providers are required to educate all participants regarding the procedure and provide adequate resolution in a timely manner. The provider grievances and appeals are monitored by DMS through certification and on-site monitoring during surveys, investigations, and technical assistance visits.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management. *Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. Select one:*

X	**Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
	No. This Appendix does not apply *(do not complete Items b through e)* *If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements

Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Commonwealth is responsible to provide a reporting process and investigation of cases of abuse, neglect, and exploitation (ANE) of waiver participants using the following Kentucky statutes and administrative regulations:

- "Abuse" as defined in KRS 209.020(8) and 922 KAR 5:070
- "Sexual Abuse" as defined in KRS 600.020(58)
- "Exploitation" as defined in KRS 209.020(9) and 922 KAR 5:070
- "Neglect" as defined in KRS 209.020(16) and 922 KAR 5:070

For organizational and prioritization purposes, the Department for Medicaid Services (DMS) classifies incidents into non-critical incidents and critical incidents, which DMS defines as follows. Other sections of this appendix describe the process for categorizing and investigating these incidents**:**

- Non-critical incidents include:
    - Use of emergency medical care due to an emergent episode of an illness that does not require hospital admission
    - Provider administered medication errors that do not result in medical intervention

- Minor motor vehicle accidents of a participant while receiving Medicaid reimbursed services
- Moderate injury

- Critical incidents include:
  - Elopement or missing person
  - Incidents involving law enforcement intervention
  - Provider administered medication errors that require medical intervention
  - Serious behaviors
  - Suspected abuse, neglect, or exploitation of a participant including:
    - Mental Abuse
    - Sexual Abuse
    - Physical Abuse
    - Neglect
    - Self-Neglect
    - Exploitation
  - Unnatural Death
  - Natural Death
  - Provider's use of a physical or chemical restraint or seclusion
  - Unplanned hospital admission
  - Theft of participant's personal property or funds
  - Three or more slips and falls in a three (3) month period
  - Three or more non-critical incidents of the same incident type in a three (3) month period
  - Three or more consecutive missed doses of the same medication
  - Any other situation affecting the health, safety, and welfare of the participant

Identification of the individuals/entities that must report critical events and incidents:

Any individual who witnesses or discovers a critical or non-critical incident is responsible to report it. This includes, but is not limited to, all persons as defined in KRS 209.030(2) and KRS 620.030.

The timeframes within which critical and non-critical incidents must be reported:

Any individual who witnesses or discovers an incident should immediately take steps to ensure the participant's health, safety, and welfare, and notify the necessary authorities, including calling law enforcement and reporting any suspected ANE or financial exploitation to the Department for Community Based Services (DCBS). DCBS is part of the Cabinet for Health and Family Services (CHFS) and operates both Adult and Child Protective Services (APS and CPS).

For critical incidents, the participant's guardian/authorized representative shall be notified immediately following notifications to law enforcement and/or APS/CPS, unless he/she has suspected involvement. DMS defines "immediately" as making the notification as soon as possible but no later than eight (8)

hours after the incident. The participant's case manager (CM) or participant-directed case manager (PDCM) shall also be notified immediately. DMS shall be notified via a critical incident report entered into the DMS-approved system or other approach approved by DMS by the CM, PDCM, or provider. If the critical incident is discovered or occurs during regular business hours, DMS must be notified the same day. If the critical incident occurs or is discovered outside of regular business hours, defined as 8:00 a.m. to 4:00 p.m. EST Monday through Friday and excluding state and federal holidays, DMS must be notified the next business day. The provider agency must begin its investigation into the critical incident immediately upon occurrence or discovery and submit a full, written investigative report to DMS within five (5) business days.

For non-critical incidents, the participant's guardian and/or authorized representative and CM/PDCM shall be notified within twenty-four (24) hours upon occurrence or discovery of the incident. DMS shall be notified via a critical incident report entered into the DMS-approved system or other approach approved by DMS by the CM, PDCM, or provider. If the non-critical incident is discovered or occurs during regular business hours, DMS shall be notified the same day. If the non-critical incident occurs or is discovered outside of regular business hours, DMS shall be notified the next business day. The provider agency shall identify the root cause and conduct risk mitigation. The provider agency describes its risk mitigation strategy on its initial report to DMS.

DMS or its designee reviews critical and non-critical incident summary data generated by the DMS approved system to identify systemic issues and conduct follow-up activities as warranted. The method of reporting:

DCBS operates both a telephone hotline and an online system for reporting suspected ANE of an adult or child. Reporters can reach the Child Protection Hotline, toll-free, at 1-877-597-2331 to report suspected ANE of both an adult or child. The phone line is staffed twenty-four (24) hours a day, seven (7) days a week including weekends and holidays. Reporters can also contact their local DCBS office to report suspected ANE.

There is also an online system for reporting suspected ANE. This system is available for reporting non-emergency situations that do not require an urgent response. The website is monitored from 8:00 a.m. to 4:30 p.m. EST, Monday through Friday. Reports are not reviewed on evenings, weekends, or state holidays. If a child or adult is at immediate risk of abuse or neglect that could result in serious harm or death, it is considered an emergency and should be reported to local law enforcement or 911.

Any person making such a report shall provide the following information, if known:

(a) The name, age, and address or location where the child or adult can be found and/or any other person responsible for their care

(b) The nature and extent of the ANE, including any evidence of previous ANE

(d) The identity of the suspected perpetrator

(e) The name and address of the reporter, if they choose to be identified

(f) Any other information that the person believes might be helpful in establishing the cause of the abuse, neglect, or exploitation.

Those who witness or discover a non-critical or critical incident shall report it to DMS using the DMS-approved system. It is the provider's responsibility to contact all pertinent entities including but not limited to CM/PDCM, law enforcement, and protective services.

c. Participant Training and Education

Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

It is a responsibility of the participant's chosen CM/PDCM to ensure that the participant and their caregiver are educated about ANE and the methods available to report ANE. When a participant opts to employ Participant-Directed Services (PDS) workers, the PDCM is responsible to ensure that all workers employed by the participant are trained on mandatory reporting laws for ANE reporting.

During the CM/PDCM's initial visit with the participant, the CM/PDCM provides information and resources to the participant, the participant's guardian and/or authorized representative, if applicable, and anyone else designated by the participant regarding strategies to identify, prevent, report, and intervene in any instances or potential instances of ANE. Upon completion of this discussion, the CM/PDCM reviews a DMS approved form developed by DMS with the participant. The participant signs this form, attesting to their understanding of ANE and how these critical incidents can be prevented, reported, and addressed. The CM/PDCM retains the original of this document and provides the participant and caregiver with a copy for their record. A copy is also uploaded to the DMS approved system and is available to DMS. Participants and their caregivers are asked to attest to their knowledge and training on ANE and critical incidents annually. A copy of contact information for appropriate protection agencies must be provided and explained to each participant and/or guardian/authorized representative, if applicable. Training and communication must be provided to participant in a manner that is appropriate for their learning style.

The PDCM is also responsible for monitoring and oversight of PDS employee training. The PDCM notifies the PDS employee of DMS mandatory trainings and the timeframe in which the employee must complete these trainings. PDS training is provided through DMS-developed materials.

Depending upon the individual needs of each participant, additional training or information shall be made available and related needs addressed in the participant's person-centered service plan (PCSP).

DMS requires all providers, both traditional and PDS, to complete training on ANE identification and reporting.

d. Responsibility for Review of and Response to Critical Events or Incidents

Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The response below describes DMS's role in reviewing and responding to critical and non-critical incidents. DMS cooperates with other investigative agencies, including APS/CPS, operating agencies, and law enforcement, to complete investigative activities in a timely manner with minimal stress to the participant.

<u>The entity that receives reports of each type of critical event or incident:</u>

DMS shall be notified of any incident, critical or non-critical, via an incident report uploaded to the DMS-approved system or other approach approved by DMS. This shall be done the same day if the incident occurs or is discovered during regular business hours or the next business day if the incident occurs or is discovered outside of business hours. Suspected ANE must also be reported to DCBS immediately.

<u>The entity that is responsible for evaluating reports and how reports are evaluated:</u>

Upon receiving the report, DMS becomes responsible for evaluating reports. DMS evaluates and classifies the report as a non-critical or critical incident. DMS may upgrade or downgrade an incident based on the report. This takes place within two (2) business days for critical incidents and five (5) business days for non-critical incidents.

(a) A non-critical incident shall:

1. Be reviewed by DMS and appropriately classified as a critical or non-critical incident within five (5) business days. DMS reserves the right to escalate any categorical non-critical incident to a critical incident as circumstances require;

2. Be minor in nature and not create a serious consequence or risk for participants;

3. Not require an on-site DMS or its designee investigation and consist of only desk review, telephonic interview, etc.;

4. Be reported on by the provider to DMS and monitored for future follow-up and intervention as appropriate.

(b) A critical incident shall:

1. Be reviewed by DMS or its designee and appropriately classified as a critical or non-critical incident within two (2) business days and the investigative process will be initiated as appropriate;

2. Be serious in nature;

3. Pose immediate risk to health, safety, or welfare of the participant, co-residing participants, or others;

4. Be investigated and reported on by the provider to DMS. An investigation report must be completed within five (5) business days of the incident;

5. Warrant an on-site DMS investigation as needed.

The timeframes for conducting and completing an investigation:

Individuals who discover or witness an incident shall immediately ensure the participant's health, safety, and welfare, and contact the proper authorities, including law enforcement and/or APS/CPS.

For both critical and non-critical incidents, the participant's guardian/authorized representative and CM/PDCM shall be notified as soon as the above steps have been taken.

Once these steps have been taken, the provider agency initiates an investigation into the incident based on its classification as follows:

Non-Critical Incidents

The provider agency is expected to identify the root cause and conduct risk mitigation. The provider agency describes its risk mitigation strategy on its initial report to DMS.

DMS reviews the non-critical incident within five (5) business days of receiving the non-critical incident report. Based on the report's findings, DMS may require more information or escalate the incident to a critical incident. If the non-critical incident is escalated to a critical incident, the critical incident processes below will be applied.

Critical Incidents

Provider agencies must initiate investigations of critical incidents immediately upon occurrence or discovery. DMS shall be notified, via an incident report entered into the DMS-approved system, the same day if the incident occurs or is discovered during business hours and the next business day if it occurs or

is discovered outside of business hours. DMS or its designee conducts a review of the critical incident within two (2) business days of notification. DMS or its designee may intervene when deemed necessary and conduct an investigation within fourteen (14) business days of notification if the incident involves physical abuse and neglect that results in death or potentially life-threatening or serious injury or illness. APS/CPS and/or law enforcement investigations may take longer. DMS will maintain a memorandum of understanding with APS/CPS regarding the results of investigations and will take appropriate action based on the final outcome. The provider must upload a complete, investigative report on the critical incident within five (5) business days of occurrence or discovery to the DMS approved system. This report only includes provider findings.

All waiver providers are expected to meet the standards set forth in their provider agreement with DMS, DMS ANE training, DMS waiver certification, and/or OIG licensure regarding ANE/critical incident investigations and reporting.

The entity that is responsible for conducting investigations and how investigations are conducted:

Providers conduct and upload investigations on critical and non-critical incidents, as warranted, to the DMS approved system.

In opening and initiating an investigation, DMS or its designee contacts and coordinates with APS/CPS, law enforcement, and other responsible agencies immediately if needed. DMS or its designee must conduct investigations in coordination with these parties to ensure the participant's health, safety, and welfare.

DMS or its designee must also assist and support investigations in accordance with Kentucky statute and administrative regulations, including 922 KAR 1:330, 922 KAR 5:070, KRS 620.030, and KRS 209.030.

DMS or its designee will conduct an investigation using methods determined appropriate during the incident classification process, and will intervene to address imminent health, safety, or welfare concerns of a participant as deemed necessary, based on the reporting and investigatory information obtained. As part of the investigation, DMS or its designee staff may interview parties involved in the incident including provider staff, participants, witnesses, or other parties. In addition, DMS or its designee may request and review medical reports, claims data, police reports, and other pertinent documentation to support DMS's investigation. If necessary, DMS or its designee may also conduct an on-site investigation to inspect the participant's environment at home or in a provider facility. If the investigation report results in documentation of regulatory non-compliance, a findings letter including citations, impositions of a corrective action plan (CAP), and/or sanctions is generated and sent to the provider agency via mail.

e. Responsibility for Oversight of Critical Incidents and Events

Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DMS is responsible to oversee reporting of and response to critical incidents affecting waiver participants. DMS or its designee will conduct an investigation and will intervene to address imminent health, safety, or welfare concerns of a participant as deemed necessary. DMS tracks and trends all incident reports. DMS or its designee may conduct follow-up monitoring visits, technical assistance, or provider training as needed, based on trend analysis. Trend analysis monitors the following data elements:

- Nature of the incident
- Frequency of incidents
- Adherence to time standards
- CAP status

- High frequency providers
- Recurring participants
- Rate of unreported incidents identified via MMIS claims data

All incident reports are submitted through the DMS-approved system or other approach approved by DMS. DMS samples a select number of providers and verifies through certification surveys, monitoring visits, or investigations that critical incidents were appropriately addressed and that the provider agency is following up appropriately.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

X	**The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Kentucky recognizes that person-centered thinking and planning is key to prevention of risk of harm for all participants. It is the responsibility of all service providers to utilize person-centered thinking as a means of crisis prevention.

Kentucky is dedicated to fostering a restraint-free environment in all waiver programs. DMS prohibits the use of mechanical or chemical restraints, seclusion, manual restraints, including any manner of prone (breast-bone down) or supine (spine down) restraint, is prohibited.

DMS also prohibits the use of chemical restraints. DMS defines a chemical restraint as the use of a medication, either over the counter or prescribed, to temporarily control behavior or restrict movement or functioning of a participant and is not a standard treatment for the participant's medical or psychiatric diagnosis.

A psychotropic per required need (PRN) is a pharmacological intervention defined as the administration of medication for an acute episodic symptom of a participant's mental illness or psychiatric condition and is not considered a chemical restraint. All administration must adhere to a physician's order that shall include drug, dosage, directions, and reason for use. The PCSP, risk mitigation form, and behavior support plan, if applicable, shall incorporate the protocol for use of a psychotropic PRN and is applicable to participants in DMS approved provider sites.. These are reviewed annually as part of the person-centered planning process or more often if needed.

DMS is responsible for oversight of the person-centered planning process which includes monitoring of case management reports, incident reports, and complaints. The continuous quality improvement process reveals trends, patterns, and remediation necessary to ensure proper implementation of the PCSP and participant safety.

A participant has the right to be free of any physical or chemical restraints.. Any interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior must be reviewed on an annual basis. If a participant's unanticipated violent or aggressive behavior places

him/her or others in imminent danger, a restrictive intervention may be used as a last resort to maintain health, safety, and welfare.

State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

	The use of restraints is permitted during the course of the delivery of waiver services. *Complete Items G-2-a-i and G-2-a-ii.*

i. **Safeguards Concerning the Use of Restraints**. *Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Not applicable.

ii. **State Oversight Responsibility** Any incident of restraint or restrictive intervention is considered a critical incident and must be reported to DMS as articulated in G-1-b. If appropriate, the provider, CM/PDCM, or DMS may make a referral to the appropriate protective service agency. DMS incorporates this oversight into certification reviews, on-site monitoring, and investigations.

Not applicable.

b. **Use of Restrictive Interventions.** (Select one):

X	**The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DMS or its designee is responsible for detecting the unauthorized use of restrictive interventions. DMS or its designee incorporates oversight into on-site monitoring and review of critical incidents.

	The use of restrictive interventions is permitted during the course of the delivery of waiver services *Complete Items G-2-b-i and G-2-b-ii.*

i. **Safeguards Concerning the Use of Restrictive Interventions**. *Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.*

ii. **State Oversight Responsibility.** *Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:*

c. **Use of Seclusion.** (*Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

X	**The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DMS or its designee is responsible for detecting the unauthorized use of seclusion, as described in section G-2-a. DMS or its designee incorporates oversight into on-site monitoring and review of critical incidents.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** *Select one:*

	No. This Appendix is not applicable *(do not complete the remaining items)*
X	**Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. **Responsibility.** *Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.*

Entity (entities) that have responsibility for monitoring medication regimens:

Licensed waiver providers are responsible for monitoring participant medication regimens in adult day health care centers and specialized respite settings.

The methods for conducting monitoring of medication regimens:

Waiver providers are required to follow the guidelines indicated below for administration of medication:

Unless the employee is a licensed or registered nurse, ensure that staff administering medication:

1. Have DMS-approved training on cause and effect and proper administration and storage of medication, documentation requirements, and appropriate disposal. Training must occur at time of hire, annually, and as needed. Attendance and competency must be documented and maintained in provider personnel records.

2. Document of all medication administered, including self-administered, over-the-counter drugs, on a medication administration record (MAR), with the date, time, and initials of the person who administered the medication and supervisor's validate appropriate administration and documentation through a process approved by DMS or its designee. . DMS or its designee reviews during the certification processes. DMS or its designee conducts certification every two (2) years or more frequently if necessary.

3. Ensure the medication shall:

a. Be kept in a locked cabinet or storage unit;

b. Be kept in a pharmacy labeled container or original package with participant's name and expiration date;

c. Be properly disposed of as needed;

d. If a controlled substance, be kept under double lock. Documented by a cumulative monthly log with drug name and dosage with a daily medication count verified by two individuals with signature, title, date, and time.

In addition, waiver providers are required to have policy and procedures for on-going monitoring of medication administration, which must be approved by DMS or its designee.

Frequency of medication regimen monitoring:

ii. A provider agency supervisor should verify appropriate administartion of medication on a frequency approved by DMS or its designee during the provider certification and re-certification process.
Methods of State Oversight and Follow-Up. *Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.*

DMS or its designee is responsible for oversight of medication management practices by licensed waiver providers. This oversight begins with review and approval of providers' policy and procedures for on-going monitoring of medication administration. DMS or its designee assesses medication administration policies, practices, and record-keeping, and necessary interventions employed, as part of the certification and on-site monitoring process, which occurs at least every two (2) years. In addition, all medication errors must be reported through the incident reporting system, as defined in G-1-d.

Providers deemed non-compliant with medication management requirements may receive technical assistance, CAPs, or sanctions depending on the frequency and severity of the non-compliant action. DMS or its designee conducts additional evaluation and investigation for any medication error classified as a critical incident and any recurrent errors classified as a critical incident, which is defined as three incidents occurring within the same provider location, within a three-month period, regardless of whether it is the same staff member responsible for the error.

c. Medication Administration by Waiver Providers

i. ***Provider Administration of Medications.*** *Select one:*

	Not applicable. *(do not complete the remaining items)*
X	***Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.*** *(complete the remaining items)*

ii. ***State Policy.*** *Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Licensed waiver providers may be responsible for medication administration. Those who choose to be responsible receive training on medication administration. G-3-b-I of this appendix describes the DMS policy regarding medication regimen reviews. In addition to these monitoring standards, the

Commonwealth provides guidance to providers through state law, regulations, and policies. State laws, regulations, and policies will be made available to CMS upon request through the Medicaid agency or the operating agency.

iii. ***Medication Error Reporting.*** Select one of the following:

X	***Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).*** *Complete the following three items:*

a. Specify State agency (or agencies) to which errors are reported:

All errors are reported to the DMS through the DMS approved incident reporting system and investigated in accordance with section G-1-D of this appendix.

b. *Specify the types of medication errors that providers are required to record:*

A medication error occurs when a participant receives an incorrect drug, dose, form, quantity, route, concentration, or rate of administration from a provider. A medication error is also defined as the variance of the administration of a drug on a schedule other than intended in the prescription instructions. Therefore, a missed dose or a dose administered more than one hour before or after the scheduled time constitutes a medication error. Providers must record two levels of medication errors while a participant is in their care as follows:

Non-Critical: Incidents in which the person experienced no or minimal adverse consequences and no treatment or intervention other than monitoring or observation was required.

Critical: Incidents in which the person experienced short term, reversible adverse consequences and treatment or intervention was needed in addition to monitoring and observation OR incidents in which the person experienced life- threatening or permanent adverse consequences.

c. *Specify the types of medication errors that providers must report to the State:*

All medication errors as defined in section G-3-c-iii-b must be reported to the State. Providers must report non-critical errors following the non-critical incident timeframes set forth in section G-1-B. Providers must report critical errors following the critical incident timeframes set forth in section G-1-B.

iv. ***State Oversight Responsibility.*** *Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.*

DMS or its designee is responsible for monitoring waiver providers' performance in administration of medication. This oversight begins with review and approval of provider policy and procedures for on-going monitoring of medication administration. DMS or its designee assesses medication administration policies, practices, and record-keeping, and necessary interventions employed, as part of the certification, on-site monitoring, and incident reporting process, which occurs as deemed necessary by DMS or its designee. In addition, all medication errors must be reported through the incident reporting system and will be followed up on as warranted.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

a. **Methods for Discovery:**

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death*					
Performance measure:	Percent of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death. N= Number of waiver participants (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death when asked during participant satisfaction surveys. D= Number of waiver participants included in participant satisfaction surveys.					
Data Source: Case Management Monitoring documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
	X	*Operating Agency*		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other	X	*Annually*

		Specify:		
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death*					
Performance measure:	Percent of abuse, neglect, exploitation and unexplained death incidents reported within the required timeframe. N= Number of critical incident reports of potential abuse, neglect, exploitation and unexplained death submitted in timeframe. D= Number of critical incident reports of potential abuse, neglect, exploitation and unexplained death					
Data Source: Critical incident documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other *Specify:*	X	*Annually*

				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death*					
Performance measure:	Percent of abuse, neglect, exploitation and unexplained death incidents reviewed/investigated within the required timeframe. N= Number of critical incident reports of potential abuse, neglect, exploitation and unexpected death that were reviewed/investigated within the required timeframe. D= Number of critical incidents received.					
Data Source: Critical incident documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**			
	X	*State Medicaid Agency*		*Weekly*		
		Operating Agency		*Monthly*		
		Sub-State Entity	*X*	*Quarterly*		
		Other *Specify:*	*X*	*Annually*		

				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death*					
Performance measure:	Percent of substantiated abuse, neglect, exploitation and unexplained death incidents where required/recommended follow-up (safety plans, corrective action plans, provider sanctions, etc.) was completed. N= Number of DMS-required follow-ups completed by providers and submitted to DMS. D=Number of DMS-required follow-ups issued to providers.					
Data Source: Critical incident documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**			
	X	*State Medicaid Agency*		*Weekly*		
		Operating Agency		*Monthly*		
		Sub-State Entity	X	*Quarterly*		
		Other *Specify:*	X	*Annually*		

				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death*					
Performance measure:	Percent of substantiated abuse, neglect, exploitation and unexplained death incidents that were referred to appropriate investigative entities (e.g., Law Enforcement, APS/CPS) for follow-up. N=Number of substantiated abuse, neglect, exploitation and unexplained death incidents referred to appropriate investigative entities (e.g., Law Enforcement, APS/CPS) for follow-up. D= Number of substantiated ANE/unexplained death incidents.					
Data Source: Critical incident documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		
Data Aggregation and Analysis						
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**			
	X	*State Medicaid Agency*		*Weekly*		
		Operating Agency		*Monthly*		
		Sub-State Entity	X	*Quarterly*		
		Other	X	*Annually*		

		Specify:		
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*					
Sub-assurance:	*The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*					
Performance measure:	Percent of critical incidents where root cause was identified. N= Number of critical incidents where root cause was identified. D= Number of critical incidents received.					
Data Source: Critical incident documentation						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
	X	*Operating Agency*		*Monthly*	X	*Less than 100% Review* *Confidence interval: 95%*
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: Delegated Entity*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other	X	*Annually*

		Specify:		
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.*
Sub-assurance:	*The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*
Performance measure:	Percent of participants reviewed who received information and support to access state plan services identified in their person-centered plan. N= Number of participants reviewed who received support to access state plan services. Denominator: Number of participants in the sample with state plan services identified in their PCSP.

Data Source: Participant survey

	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*		*100% Review*
		Operating Agency		*Monthly*	X	*Less than 100% Review* *Confidence interval:* 95%
		Sub-State Entity	X	*Quarterly*		*Representative Sample* *Confidence interval=*
		Other *Specify:*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis

	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity	X	*Quarterly*
		Other	X	*Annually*

		Specify:		
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible*.

Licensed provider agencies are reviewed every three (3) years by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks. Licensed and certified agencies are reviewed by DMS or its designee every two years or more frequently as required. DMS or its designee performs 1st line monitoring and identifies deficiencies of the HCB waiver provider. This monitoring includes, but not limited to reviewing complaint logs, MARs, policies and procedures of providers for grievances and complaints, etc. During the monitoring DMS or its designee will review the procedures of the provider that train employees and ensure the health, safety, and welfare of the participants and that incidents are reported appropriately. DMS or designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys. Providers must ensure that waiver participants have access to agency staff and know their case managers name and contact information.

DMS or its designee monitors the complaint process by examining complaint logs and the results of client satisfaction surveys.

Providers must ensure that waiver participants have access to agency staff and know their case managers name and contact information.

Require providers to make the toll-free Fraud and Abuse Hotline telephone number of the Office of Inspector General available to agency staff, waiver participants and their caregivers or legal representatives, and other interested parties; The purpose of this telephone Hotline is to enable complaints or other concerns to be reported to the Office of Inspector General.

b. Method for Remediation/Fixing Individual Problems

i. *Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items*.

Licensed provider agencies are reviewed every three (3) years by the OIG which includes the monitoring of the employees records for criminal checks and abuse registry checks. Licensed and certified agencies are reviewed by DMS or designee. Should an enrolled provider not meet requirements to provide services, OIG would notify Program Integrity. DMS or its designee performs 1st line monitoring and audit reviews.

All documentation concerning the monitoring process for providers is kept for a period of five (5) years after last claim is processed or expiration of the contract, whichever is sooner.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):	**Frequency of data aggregation and analysis (check each that applies):**

X	*State Medicaid Agency*		*Weekly*
	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
	Other *Specify:*	X	*Annually*
			Continuously and Ongoing
			Other *Specify:*

c. Timeline

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

X	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation.*

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- *Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.*

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-

assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- *The evidence based discovery activities that will be conducted for each of the six major waiver assurances;*
- *The remediation activities followed to correct individual problems identified in the implementation of each of the assurances;*

In Appendix H of the application, a State describes (1) the system improvement activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent roles/responsibilities of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously assess the effectiveness of the OIS and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

a. System Improvement

i. *Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.*

DMS or its designee collects data from a variety of sources to help understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. DMS has defined its quality-related operational elements including data aggregation, measurement, and reporting activities which promotes consistent, rigorous quality management approaches that are institutionalized within Cabinet operations and culture. DMS determined what data should be collected based on several factors including; relevance to participant health and welfare, reliability of data, importance to DMS operational goals, ease and feasibility of data collection, among other factors. The information collected includes data from: LOC determinations; service authorization, service and expenditure reports; individual plans and outcomes; incident reports; consumer surveys; monitoring visits; progress toward achieving corrective action plan goals; and recertification reviews.

DMS analyzes the aggregate data based on established performance targets related to each data point. DMS evaluates data collected against these performance targets to identify

performance gaps. As gaps are identified, DMS evaluates program-wide data in a manner that enables DMS staff to observe overarching trends and to “drill down” to observe differences among various geographies, waivers, subpopulations, etc. so that the DMS can begin to understand potential root causes of performance patterns and variation. Subsequently, DMS identifies opportunities to improve operational processes based on performance gaps and trends. DMS prioritizes the process improvement to address performance gaps and trends based on the measure. DMS strategically identifies opportunities to enhance operational processes based on how the process can improve participant health and welfare, strengthen compliance with federal regulations and guidance, improve efficiencies of staff resource use, among other factors.

Implementation of system improvements is dependent on the performance gap. DMS will assess the performance gap and identify the root cause to be addressed. DMS or its designee, will develop a tailored implementation plan, identify needed staff, determine the steps, sequence, and timeline for system improvement so performance gaps can be addressed in a timely manner.

ii. System Improvement Activities

Responsible Party (check each that applies):		**Frequency of Monitoring and Analyses (check each that applies):**	
X	*State Medicaid Agency*		*Weekly*
	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
	Quality Improvement Committee	X	*Annually*
	Other *Specify:*		*Other* *Specify:*

b. System Design Changes.

i. *Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.*

DMS continually monitors system design changes by evaluating the performance data pre and post-implementation of system changes. DMS establishes performance goals when implementing systems redesign and regularly tracks the progress towards meeting these goals. DMS will monitor the implementation of system improvements through regularly schedule meetings, progress towards key milestone, and continuous monitoring of performance measures. DMS reserves the right to increase the frequency or number of measures collected during system change implementation to identify unforeseen impacts of the system change plan. DMS can modify its design changes based on outcomes indicated by its performance data. As new performance gaps arise, DMS prioritizes additional systems changes to address these gaps. DMS or its designee creates reports to track progress of these systems improvements and discusses progress and with the appropriate parties. This process continues as DMS improves its operations to meet its program-wide goals.

ii. *Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.*

The Cabinet is shifting its approach to re-orient its quality management activities from the current compliance focus to one that recognizes the importance of both regulatory compliance and quality improvement to promote improved participant outcomes and other performance improvements. DMS is creating a quality strategy that mirrors this shift in approach. DMS has selected performance measures that allows DMS the ability to understand the effectiveness and quality of its current waiver operations. The data collected provides meaningful insights and informs decisions related to process and systems improvement. DMS regularly reviews each of its core 1915(c) waiver operations and identifies opportunities to modify existing measures or add measures to appropriately monitor its operational effectiveness. In addition, DMS performs a formal annual review of its quality strategy and revises, as needed.

H-2. Use of a Patient Experience of Care/Quality of Live Survey

a. *Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (select one*):

	No
	Yes (complete item H.2.b

b. Specify the type of survey tool the state uses:

	HCBS CAHPS Survey
	NCI Survey
	NCI AD Survey
X	*Other (Please provide a description of the survey tool used): Participants are surveyed during provider certification to determine satisfaction. The tool was developed by the state to review community involvement and quality of life.* Participants are surveyed during provider certification to determine satisfaction. The tool was developed by the state to review community involvement and quality of life.

Appendix I: Financial Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Department for Medicaid Services (DMS) or its designee conduct annual utilization audits of all waiver providers. These audits include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver participant. DMS or its designee shall utilize reports generated from the Medicaid

Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved PCSP shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved POC, DMS will initiate recoupment of the monies. Additional billing reviews are conducted based on issues identified during certification surveys or investigations. DMS or its designee may require corrective action plans and/or recoupment monies for failing to meet audit requirements.

DMS or its designee shall conduct annual audits of the financial management services (FMS) entities. These audits include a post-payment review of Medicaid reimbursement to the financial management agency for payment to the participant's employees through participant directed opportunities. Auditing will be conducted through random sample of all participant directed records. DMS or its designee shall utilize reports generated from MMIS reflecting each service billed for each participant by financial management agency. Comparison of payments to participant records, documentation and approved PCSP shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with the approved PCSP, DMS or its designee will initiate recoupment of the monies. Additional billing reviews shall be conducted based on issues identified during these post payment audits.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

a. **Methods for Discovery:**

Methods for Discovery:	*The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.*					
Sub-assurance:	*The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*					
Performance measure:	Number and percent of claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered on the participant's plan of services. N=Number of claims coded and paid in accordance with methodology and on only for services rendered on the participant's plan of services. D=Number of claims coded and paid.					
Data Source: Financial records (including expenditures)						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
		Operating Agency		*Monthly*		*Less than 100% Review* *Confidence interval:*
		Sub-State Entity		*Quarterly*		*Representative Sample*

						Confidence interval=
	X	*Other* *Specify: MMIS*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity		*Quarterly*
	X	*Other* *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.*
Sub-assurance:	*The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*
Performance measure:	Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the service delivery date. N= Number of waiver service claims that were submitted for participants who were enrolled in the waiver on the service delivery date. D= Number of waiver service claims.

Data Source: Financial records (including expenditures)						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
		Operating Agency		*Monthly*		*Less than 100% Review* *Confidence interval:*

		Sub-State Entity		*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: MMIS*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity		*Quarterly*
	X	*Other* *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

Methods for Discovery:	*The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.*
Sub-assurance:	*The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*
Performance measure:	Number and percent of rates that remain consistent with the approved rate methodology throughout the five year waiver cycle. N=Number of rates that remain consistent with rate methodology throughout waiver period. D=Number of rates

Data Source: Financial records (including expenditures)						
	Responsible Party for data collection/generation (check each that applies):		**Frequency of data collection/generation (check each that applies):**		**Sampling Approach (check each that applies**	
	X	*State Medicaid Agency*		*Weekly*	X	*100% Review*
		Operating Agency		*Monthly*		*Less than 100% Review* *Confidence interval:*

		Sub-State Entity		*Quarterly*		*Representative Sample* *Confidence interval=*
	X	*Other* *Specify: MMIS*	X	*Annually*		*Stratified.* *Describe Group:*
				Continuously and Ongoing		*Other* *Specify:*
				Other *Specify:*		

Data Aggregation and Analysis				
	Responsible Party for data aggregation and analysis (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
	X	*State Medicaid Agency*		*Weekly*
		Operating Agency		*Monthly*
		Sub-State Entity		*Quarterly*
	X	*Other* *Specify:*	X	*Annually*
				Continuously and Ongoing
				Other *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible*.

DMS reviews and adds Edits/Audits to the Medicaid Management Information System (MMIS) periodically for program compliance and as policy is revised to ensure claims are not paid erroneously.

DMS reviews the CMS-372 report for accuracy prior to submission.

b. Method for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

DMS or Designee provides technical assistance to certified providers on an ongoing basis. Providers found out of compliance submit and are held to a plan of correction (POC). DMS or Designee performs trainings upon request of providers and provides technical assistance whenever requested. Should an enrolled provider fail to meet their POC, DMS may terminate the provider's enrollment as a waiver provider.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification).

Responsible Party (check each that applies):		**Frequency of data aggregation and analysis (check each that applies):**	
X	*State Medicaid Agency*		*Weekly*
	Operating Agency		*Monthly*
	Sub-State Entity	X	*Quarterly*
X	*Other* *Specify:*	X	*Annually*
			Continuously and Ongoing
			Other *Specify:*

c. Timeline

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

X	**No**
	Yes *Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for this operation*.

Appendix I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

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Provider rates are established utilizing a fee-for-service system. Paid claim data was reviewed for waiver participants for sates of service, fiscal years 2011-2014, which included total units paid per service, total unduplicated users, total cost, average units of service and average cost. Data was trended forward, using historical information, factoring in rate of growth. Some rates were adjusted up or down to address underutilization, or to bring them into closer alignment with rates to similar services in other Kentucky 1915 (c) waiver programs. For new services, rates were established based on rates paid for similar services in other Kentucky Cabinet for Health and Family Services programs.

Rates are established by the Kentucky Department for Medicaid Services and incorporated into Kentucky Administrative Regulations. All new and amended administrative regulations are subject to a public comment process during promulgation.

b. **Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Billings for waiver services shall flow directly from the waiver providers to the Commonwealth's MMIS.

Appendix I-2: Rates, Billing and Claims (2 of 3)

c. Certified Public Expenditures. (*select one*):

X	**No. State or local government agencies do not certify expenditures for waiver services.**
	Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

	Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

	Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided*:

All waiver providers shall be enrolled with the Department for Medicaid Services (DMS) Program Integrity (PI), provider enrollment, and have a signed contract on file. The Medicaid Management Information System (MMIS) has edits and audits established to prevent non-enrolled provider claims from processing. DMS or its designee shall conduct audits of all waiver providers. These audits shall include a post-payment review of Medicaid reimbursement to the provider agency for services rendered to a waiver

participant. The DMS or its contractors shall utilize reports generated from the Medicaid Management Information System (MMIS) reflecting each service billed by the waiver provider. Comparison of payments to participant records, documentation and approved Plan of Care (POC) shall be conducted. If any payments were issued without the appropriate documentation or not in accordance with approved PCSP, DMS shall initiate recoupment of the monies.

Appendix I-3: Payment (1 of 7)

a. Method of payments – MMIS. Select One:

X	**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
	Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

	Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
X	**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. Select one*:

X	**No. The State does not make supplemental or enhanced payments for waiver services.**
	Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

	No. State or local government providers do not receive payment for waiver services. *Do not complete Item I-3-e.*
X	***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Local Health Departments can provide case management.

Local Area Agencies on Aging and Independent Living can provide PDC if the AAAIL chooses not to perform any other services other than case management. Otherwise, the AAAIL may provide attendant care, respite and nutrition services.

Appendix I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.** *Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one: (If you answered "No." in Appendix I-3-d, you do not need to complete this section.)*

X	**The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
	The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

X	**Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

X	**No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

X	**No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
	Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. Select one:

X	**The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
	This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the State source or sources of the non-federal share of computable waiver costs. Select at least one*:

X	**Appropriation of State Tax Revenues to the State Medicaid agency**

	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

	Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One*:

X	**Not Applicable.** *There are no local government level sources of funds utilized as the non-federal share.*	
	Applicable *Check each that applies*:	
		Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

		Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

X	**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**	
	The following source(s) are used *Check each that applies*:	
		Health care-related taxes or fees
		Provider-related donations
		Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

X	**No services under this waiver are furnished in residential settings other than the private residence of the individual.**
	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** *The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:*

Appendix I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

X	**No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
	Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services.** *These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

X	**No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. Co-Pay Arrangement. *Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):*

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

	Nominal deductible
	Coinsurance
	Co-Payment
	Other charge

Specify:

Appendix I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

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ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. **Other State Requirement for Cost Sharing.** *Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one*:

X	**No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed*.

Level(s) of Care: Nursing Facility

Year *(Column A)*	**Factor D** *(Column B)*	**Factor D'** *(Column C)*	**Total: D+D'** *(Column D)*	**Factor G** *(Column E)*	**Factor G'** *(Column F)*	**Total: G+G'** *(Column G)*	**Difference: (D+ D') - (G +G')** *(Column H)*
Year 1	$ 3,716.90	$ 9,682.07	$ 13,398.97	$ 36,272.85	$ 1,631.28	$ 37,904.13	$ 24,505.16
Year 2	$ 3,776.33	$ 10,098.43	$ 13,874.76	$ 37,168.25	$ 1,559.47	$ 38,727.72	$ 24,852.96
Year 3	$ 3,858.39	$ 10,619.29	$ 14,477.68	$ 38,085.76	$ 1,490.83	$ 39,576.59	$ 25,098.91
Year 4	$ 3,913.01	$ 11,231.49	$ 15,144.50	$ 39,025.91	$ 1,425.20	$ 40,451.11	$ 25,306.61
Year 5	$ 4,043.39	$ 11,946.86	$ 15,990.25	$ 39,989.28	$ 1,362.47	$ 41,351.75	$ 25,361.50

Appendix J-2: Derivation of Estimates (1 of 9)

a. **Number of Unduplicated Participants Served**. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Waiver Year *(Column A)*	**Total Unduplicated Number of Participants** *(Column B)*	**Distribution of Unduplicated Participants by Level of Care** *(Column C)*
		Level of Care:
Year 1	17050	
Year 2	17050	
Year 3	17050	
Year 4	17050	
Year 5	17050	

Appendix J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Five years of CMS-372 report data utilized. Total days and unduplicated waiver participants have been declining at 1.5% and 3% respectively. Due to the Michele P. waiver reaching capacity there is reason to believe the persistent reduction in the HCB waiver has stopped, yet not solid enough data to forecast increases in days or participants. For that reason days and participants were maintained at the levels on the CMS 372 report with a run date of 3/13/2015.

Preserving the two factors listed above also preserved the average length of stay.

Appendix J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor**. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. **Factor D Derivation**. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:*
Waiver Services data from SFY 2010 through 2014 were identified using the CMS-372 reports.

Each service in the waiver was estimated individually. PDS and traditional users were forecast based upon 5 year average growth rates in usage of those services.

Users of each other service were based upon percentage of persons, by sub-category, using that service in SFY 2014 (For example: Home and Community Directed Support Service Users were estimated based on the share of PDS members receiving that service in SFY 2014). Total costs for unit based services, such as adult day health services, were based on estimated users and unit per user growth over the past 5 years. Total costs for non unit based services, such as Home adaptation were based on estimated users and cost per user growth over the previous 5 years.

ii. **Factor D' Derivation**. *The Estimates of Factor D' for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:*
5 years of CMS 372 report data utilized. Average growth rate of Factor D' applied to 2014 data and trended forward. Adjustment included for removal of OT/PT/ST to state plan.

iii. **Factor G Derivation**. *The Estimates of Factor G for each waiver year are located in Item J-2-d. The basis for these estimates is as follows*:
5 years of CMS 372 report data utilized. Average growth rate of Factor G applied to 2014 data and trended forward.

iv. **Factor G' Derivation**. *The Estimates of Factor G' for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:*
5 years of CMS 372 report data utilized. Average growth rate of Factor G' applied to 2014 data and trended forward.

Appendix J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Service	

Appendix J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. **Non-Concurrent Waiver.** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

WY 1						
Waiver Services/Component *(Column A)*	**Unit** *(Column B)*	**# Users** *(Column C)*	**Avg. Units Per User** *(Column D)*	**Avg. Cost per Unit (Column E)**	**Component Cost (Column F)**	**Total Service Cost**

						(Column G)
Adult Day Health Total:					**$ 30,561,707.70**	
Adult Day Health	15 minutes	3243.00	3330.00	$ 2.83	$ 30,561,707.70	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Case Management Total:					**$ 5,257,600.00**	
Case Management	1 month	6572	8.00	$ 100.00	$ 5,257,600.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Specialized Respite Total:					**$ 2,104,557.00**	
Specialized Respite Total:	15 minutes	1183.00	444.75	$ 4.00	$ 2,104,557.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Participant Directed Case Management Total:					**$ 5,220,800.00**	
Participant Directed Coordination:	2 units per month	4016.00	8.00	$ 162.50	$ 5,220,800.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Personal Assistance Total:					**$ 3,096,720.00**	
Attendant Care Total:	15 minutes	5610.00	92.00	$ 6.00	$ 3,096,720.00	
[Additional Service Component Titles]					$ -	

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Environmental and Minor Home Modifications Total:					**$ 2,173,752.00**	
Environmental and Minor Home Adaptation Total:	annual	4540.00	180.00	$ 2.66	$ 2,173,752.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Goods and Services Total:					**$ 2,996,106.00**	
Goods and Services Total:	each	3886.00	771.00	$ 1.00	$ 2,996,106.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Home and Community Support Total:					**$ 5,355,789.12**	
Home and Community Support Total:	15 minutes	3597.00	517.00	$ 2.88	$ 5,355,789.12	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Home Delivered Meals Total:					**$ 5,335,680.00**	
Home Delivered Meals Total:	each	3176.00	224.00	$ 7.50	$ 5,335,680.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Non-Specialized Respite Total:					**$ 1,270,384.50**	

Non-Specialized Respite Total:	15 minutes	647.00	714.00	$ 2.75	$ 1,270,384.50	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
				Grand Total:	$ 63,373,096.32	
				Total Estimated Unduplicated Participants:	17050	
				Factor D (Divide total number of Participants):	$ 3,716.90	
				Average Length of Stay on the Waiver:	315	

Appendix J-2: Derivation of Estimates (6 of 9)

e. Estimate of Factor D.

ii. **Non-Concurrent Waiver.** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

WY 2						
Waiver Services/Component *(Column A)*	**Unit** *(Column B)*	**# Users** *(Column C)*	**Avg. Units Per User** *(Column D)*	**Avg. Cost per Unit (Column E)**	**Component Cost (Column F)**	**Total Service Cost (Column G)**
Adult Day Health Total:					**$ 30,156,010.22**	
Adult Day Health	15 minutes	3178.00	3353.00	$ 2.83	$ 30,156,010.22	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	

Case Management Total:					**$ 4,936,800.00**
Case Management	1 month	6171	8.00	$ 100.00	$ 4,936,800.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Specialized Respite Total:					**$ 1,976,469.00**
Specialized Respite Total:	15 minutes	1111.00	444.75	$ 4.00	$ 1,976,469.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Participant Directed Case Management Total:					**$ 6,461,325.00**
Participant Directed Coordination:	2 units per month	4418.00	9.00	$ 162.50	$ 6,461,325.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Personal Assistance Total:					**$ 2,941,608.00**
Attendant Care Total:	15 minutes	5329.00	92.00	$ 6.00	$ 2,941,608.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -

[Additional Service Component Titles]					$ -
Environmental and Minor Home Modifications Total:					**$ 1,911,534.40**
Environmental and Minor Home Adaptation Total:	annual	4534.00	170.00	$ 2.48	$ 1,911,534.40
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Goods and Services Total:					**$ 2,902,842.00**
Goods and Services Total:	each	3886.00	747.00	$ 1.00	$ 2,902,842.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Home and Community Support Total:					**$ 6,188,114.88**
Home and Community Support Total:	15 minutes	3957.00	543.00	$ 2.88	$ 6,188,114.88
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Home Delivered Meals Total:					**$ 5,443,200.00**
Home Delivered Meals Total:	each	3240.00	224.00	$ 7.50	$ 5,443,200.00

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Non-Specialized Respite Total:					**$ 1,468,500.00**	
Non-Specialized Respite Total:	15 minutes	712.00	750.00	$ 2.75	$ 1,468,500.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
				Grand Total:	$ 64,386,403.50	
				Total Estimated Unduplicated Participants:	17050	
				Factor D (Divide total number of Participants):	$ 3,776.33	
				Average Length of Stay on the Waiver:	315	

Appendix J-2: Derivation of Estimates (7 of 9)

f. Estimate of Factor D.

iii. **Non-Concurrent Waiver.** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

WY 3						
Waiver Services/Component *(Column A)*	**Unit** *(Column B)*	**# Users** *(Column C)*	**Avg. Units Per User** *(Column D)*	**Avg. Cost per Unit (Column E)**	**Component Cost (Column F)**	**Total Service Cost (Column G)**

Adult Day Health Total:					**$ 29,760,217.74**
Adult Day Health	15 minutes	3114.00	3377.00	$ 2.83	$ 29,760,217.74
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Case Management Total:					**$ 5,156,100.00**
Case Management	1 month	5729	9.00	$ 100.00	$ 5,156,100.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Specialized Respite Total:					**$ 1,831,056.00**
Specialized Respite Total:	15 minutes	1031.00	444.00	$ 4.00	$ 1,831,056.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Participant Directed Case Management Total:					**$ 7,106,287.50**
Participant Directed Coordination:	2 units per month	4859.00	9.00	$ 162.50	$ 7,106,287.50
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -

[Additional Service Component Titles]					$ -
Personal Assistance Total:					**$ 2,825,154.00**
Attendant Care Total:	15 minutes	5063.00	93.00	$ 6.00	$ 2,825,154.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Environmental and Minor Home Modifications Total:					**$ 1,907,614.80**
Environmental and Minor Home Adaptation Total:	annual	4529.00	162.00	$ 2.60	$ 1,907,614.80
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Goods and Services Total:					**$ 2,809,578.00**
Goods and Services Total:	each	3886.00	723.00	$ 1.00	$ 2,809,578.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Home and Community Support Total:					**$ 7,144,243.20**
Home and Community Support Total:	15 minutes	4352.00	570.00	$ 2.88	$ 7,144,243.20

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Home Delivered Meals Total:					**$ 5,550,720.00**	
Home Delivered Meals Total:	each	3304.00	224.00	$ 7.50	$ 5,550,720.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Non-Specialized Respite Total:					**$ 1,694,607.75**	
Non-Specialized Respite Total:	15 minutes	783.00	787.00	$ 2.75	$ 1,694,607.75	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
				Grand Total:	$ 65,785,578.99	
				Total Estimated Unduplicated Participants:	17050	
				Factor D (Divide total number of Participants):	$ 3,858.39	
				Average Length of Stay on the Waiver:	315	

Appendix J-2: Derivation of Estimates (8 of 9)

g. Estimate of Factor D.

iv. **Non-Concurrent Waiver.** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

WY 4						
Waiver Services/Component *(Column A)*	**Unit** *(Column B)*	**# Users** *(Column C)*	**Avg. Units Per User** *(Column D)*	**Avg. Cost per Unit (Column E)**	**Component Cost (Column F)**	**Total Service Cost (Column G)**
Adult Day Health Total:					**$ 29,374,981.16**	
Adult Day Health	15 minutes	3052.00	3401.00	$ 2.83	$ 29,374,981.16	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Case Management Total:					**$ 4,717,800.00**	
Case Management	1 month	5242	9.00	$ 100.00	$ 4,717,800.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Specialized Respite Total:					**$ 1,672,768.00**	
Specialized Respite Total:	15 minutes	944.00	443.00	$ 4.00	$ 1,672,768.00	
[Additional Service Component Titles]					$ -	

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Participant Directed Case Management Total:					**$ 7,780,500.00**	
Participant Directed Coordination:	2 units per month	4788.00	10.00	$ 162.50	$ 7,780,500.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Personal Assistance Total:					**$ 2,683,980.00**	
Attendant Care Total:	15 minutes	4810.00	93.00	$ 6.00	$ 2,683,980.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Environmental and Minor Home Modifications Total:					**$ 1,884,788.64**	
Environmental and Minor Home Adaptation Total:	annual	4529.00	153.00	$ 2.72	$ 1,884,788.64	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Goods and Services Total:					**$ 2,720,200.00**	
Goods and Services Total:	each	3886.00	700.00	$ 1.00	$ 2,720,200.00	

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Home and Community Support Total:					**$ 8,259,874.56**	
Home and Community Support Total:	15 minutes	4788.00	599.00	$ 2.88	$ 8,259,874.56	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Home Delivered Meals Total:					**$ 5,661,600.00**	
Home Delivered Meals Total:	each	3370.00	224.00	$ 7.50	$ 5,661,600.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Non-Specialized Respite Total:					**$ 1,960,403.50**	
Non-Specialized Respite Total:	15 minutes	862.00	827.00	$ 2.75	$ 1,960,403.50	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	

			Grand Total:	$ 66,716,895.86
			Total Estimated Unduplicated Participants:	17050
			Factor D (Divide total number of Participants):	$ 3,913.01
			Average Length of Stay on the Waiver:	315

Appendix J-2: Derivation of Estimates (9 of 9)

h. Estimate of Factor D.

v. **Non-Concurrent Waiver.** *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

WY 5						
Waiver Services/Component *(Column A)*	**Unit** *(Column B)*	**# Users** *(Column C)*	**Avg. Units Per User** *(Column D)*	**Avg. Cost per Unit (Column E)**	**Component Cost (Column F)**	**Total Service Cost (Column G)**
Adult Day Health Total:					**$ 28,991,015.25**	
Adult Day Health	15 minutes	2991.00	3425.00	$ 2.83	$ 28,991,015.25	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Case Management Total:					**$ 4,237,200.00**	
Case Management	1 month	4708	9.00	$ 100.00	$ 4,237,200.00	
[Additional Service Component Titles]					$ -	

[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Specialized Respite Total:					**$ 1,500,884.00**	
Specialized Respite Total:	15 minutes	847.00	443.00	$ 4.00	$ 1,500,884.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Participant Directed Case Management Total:					**$ 9,555,000.00**	
Participant Directed Coordination:	2 units per month	5880.00	10.00	$ 162.50	$ 9,555,000.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Personal Assistance Total:					**$ 2,576,352.00**	
Attendant Care Total:	15 minutes	4568.00	94.00	$ 6.00	$ 2,576,352.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
Environmental and Minor Home Modifications Total:					**$ 1,866,458.88**	

Environmental and Minor Home Adaptation Total:	annual	4532.00	144.00	$ 2.86	$ 1,866,458.88
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Goods and Services Total:					**$ 2,634,708.00**
Goods and Services Total:	each	3886.00	678.00	$ 1.00	$ 2,634,708.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Home and Community Support Total:					**$ 9,539,464.32**
Home and Community Support Total:	15 minutes	5266.00	629.00	$ 2.88	$ 9,539,464.32
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -
Home Delivered Meals Total:					**$ 5,775,840.00**
Home Delivered Meals Total:	each	3438.00	224.00	$ 7.50	$ 5,775,840.00
[Additional Service Component Titles]					$ -
[Additional Service Component Titles]					$ -

[Additional Service Component Titles]					$ -	
Non-Specialized Respite Total:					**$ 2,262,876.00**	
Non-Specialized Respite Total:	15 minutes	948.00	868.00	$ 2.75	$ 2,262,876.00	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	
[Additional Service Component Titles]					$ -	

		Grand Total:	$ 68,939,798.45
		Total Estimated Unduplicated Participants:	17050
		Factor D (Divide total number of Participants):	$ 4,043.39
		Average Length of Stay on the Waiver:	315